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## ORIGINAL LECTURES.

### EPIDEMIC INFLUENZA OR CATARRHAL FEVER.

*Abstract of a Clinical Lecture  
delivered at the Hospital of the University of Pennsylvania,  
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BY JAMES TYSON, M.D.,  
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THE very general prevalence of an epidemic of influenza at this time, as well as the presence of numerous cases in our wards, renders appropriate some consideration of this disease. We are all familiar with sporadic cases characterized by coryza, watery eyes, pain in the brows, sometimes exceedingly severe, but generally relieved by a free purulent discharge from the nose, substituting the primary watery one. With these symptoms are often associated great muscular pain throughout the body, a certain amount of febrile movement, and sometimes cough. The whole attack lasts from three to five days, and is commonly called influenza, or "bad cold in the head." Now, what is the difference between this condition and the cases of epidemic influenza or catarrhal fever now prevailing? The same symptoms are found, with varying constancy and severity. More frequently, however, than in sporadic influenza do we have catarrhal symptoms of the respiratory passages involving the larynx, trachea, the bronchi, and, more rarely, the ultimate structure of the lungs as a pneumonia.

In the first place, epidemic influenza differs in being due to a specific cause, whereas the ordinary influenza is generally produced by exposure to cold, or by irritating matters reaching the seats involved. As the result of a specific cause the disease becomes at once "infectious." "Infectious" is a word which must be carefully distinguished from "contagious." You will remember that all contagious diseases are infectious, but not all infectious diseases are contagious. The idea of "contagion" involves that the specific cause should be derived from another person having the same disease as contrasted with "miasm," a specific cause which originates outside the organism. Now, although in consequence of the very rapid spread of epidemic influenza one is forced to ask whether it is not contagious, I am inclined with most others to place it in the second category of infectious diseases, the "miasmatic." Modern bacteriological studies have eliminated from a once long list of miasmatic diseases one after another, until malarial fever and, perhaps, yellow fever, are left alone, unless we add to the category influenza.

Beyond the somewhat fantastic ideas announced some time ago by Saulsbury, no claim of isolation has as yet been made for the germ of influenza. It is to be hoped that the abundant opportunity afforded by the prevailing

epidemic will have been taken advantage of by bacteriologists, and some definite conclusions arrived at.

The course of the cases of influenza in the present epidemic may, in general, be characterized as mild, the apparently large number of serious cases being proportionately small. Some important facts have been added to our knowledge of the disease, or, at any rate, brought afresh to our minds. The experience of almost every one has shown that the victim who yields most promptly to the disease, and goes to bed, or, at least, houses himself, is almost sure to be well in three, four, or five days. It is possible, however, for one attacked to fight off the disease without losing a day's time. But woe unto him who fails in this attempt, and as the result of taking cold, or from other cause, is forced to give up. He is either compelled to take to his bed from extreme prostration, or he suffers a relapse of the symptoms of the respiratory organs, which may extend to any depths. The prostration associated with epidemic influenza, or, at least, the present epidemic, is something peculiar. The weakness is extreme, and the slightest effort at exertion, physical or mental, promptly convinces the victim of this. The duration of the weakness is apt to be prolonged unduly, a week, or even two weeks, being required to overcome it. The recurrent pulmonary symptoms, if confined to the larger air tubes, do not give serious trouble, but if the air vesicles become invaded, the case is much more grave. A pneumonia thus occurring, is apt to be ushered in with a chill, and extends rapidly to the whole of one lung, and even to both lungs. When a part of the primary attack the pneumonia is more apt to be catarrhal and circumscribed, creeping from the bronchi into the air vesicles, and is less serious, although it may also be fatal, particularly in old persons. More rarely the inflammation is confined to the fine bronchial tubes, and we have the physical signs of a capillary bronchitis.

Another symptom which requires consideration, is the temperature. It is not commonly very high at the beginning, although I have known it to be  $106.2^{\circ}$  at the first observation in a patient now convalescent in our wards. More frequently it does not exceed  $103^{\circ}$  at the highest, and is often but slightly above the normal. The patient alluded to had been walking about with the disease up to the time of his admission. During convalescence the temperature is apt to become subnormal, falling as low as  $96^{\circ}$ , and in this patient there was a fall in four days from  $106.2^{\circ}$  to  $96^{\circ}$ . The explanation of the lowered temperature can only be had on the ground of a lowered vitality, which is also responsible for the weakness.

Another important fact in connection with epidemic influenza is this, that its presence is apt to make more serious other diseases which may occur during its prevalence. This is especially true of pneumonia, instances of which are sometimes undoubtedly regarded as secondary to influenza, when they are really primary cases. That they are signally fatal, has been amply attested by

the numerous cases which have occurred recently among us.

The *treatment* in the majority of cases is very simple. Rest in bed, without medicine, answers for a large number. Beyond this the treatment is mainly symptomatic, antipyrin for the pains when present, and quinine to keep up the strength. In ordinary cases requiring such treatment, I am in the habit of giving five grains of antipyrin every four hours, alternating with two grains of quinine as often, omitting the former when the pain has disappeared, but continuing the quinine. When the pains are very severe the antipyrin may be given more frequently, and even in larger doses. I have found it necessary also to give as much as eighteen grains of quinine daily. The cough is admirably treated with turpentine stupes, and when there are positive laryngeal symptoms, "Dobell's solution" sprayed into the larynx is very useful. It may also be sprayed into the nasal passages, or cocaine may be similarly used. Where the cough is disturbing, I have found ammonium chloride in six-grain doses, with fifteen minims of syrup of squills, and two drachms of compound licorice mixture sufficient to answer the purpose. Opium may be given in large doses if required. For the prostration, supporting measures are necessary, and even stimulants may be called for. The entire absence of appetite, and the complaint that all things taste alike, are to be ignored, and the patient must be forced to take food, which must be made as attractive as possible.

What shall we do for the pneumonia which becomes often so grave a complication? In a few cases it is a true "pneumonia fulminans"—strikes the patient down so suddenly and violently as to make all treatment unavailing. In other cases the physician reaches the patient when the disease is so advanced that depleting treatment of any kind is contra-indicated by weakness. Whether a bleeding immediately after the violent chill—even before the physical signs of a pneumonia have manifested themselves—would be of service, I have not had the opportunity of determining; but I am sure that some of my country friends would say that to omit it would be culpable. All depleting measures should be restricted to the first or, at the latest, to the beginning of the second stage of pneumonia where there are engorged vessels and more or less patulous air-vesicles. In the second stage the bloodvessels are already beginning to be compressed, and with the establishment of the second stage the lung is nearly anæmic, the distended air-vesicles compressing the bloodvessels through which the heart is trying to pump the blood. In the first stage, too, when the pulse is full and strong, *veratrum viride* may be used, as it quiets the heart, while it opens up the capillaries throughout the system and allows the lungs to empty themselves of the surplus blood. To use the expression of my colleague, Dr. Wood, concerning *veratrum viride*, you bleed the patient into his own abdominal vessels, and thus depress, while you do not exhaust him. In the second and third stages stimulants are indicated, and especially digitalis in full doses, to aid the heart in its difficult work. This should be given in doses sufficient to affect the pulse, and this effect should be kept up. Dry cupping and blistering are, in my judgment, never out of place in pneumonia, for they can do no harm, if they do no good. They should be followed by a jacket of wool, by which warmth and uniform temperature are kept up.

Beyond this there is little to be done, although an emergency may be tided over by the hypodermic use of digitalis, or of the same drug combined with ether. Under such circumstances fifteen minims of tincture of digitalis may be drawn into the syringe and the rest of the barrel filled with ether, and the mixture injected. Both may be repeated separately or conjointly.

Let me say to you, in conclusion, that one need not wait for the physical signs of a pneumonia to present themselves before beginning the treatment. Given a chill after exposure, with no other cause to explain it, and you may consider a pneumonia as almost inevitable. Oftentimes a pneumonic focus in the centre of a lung does not furnish any physical signs, while to wait until it approaches the surface causes a delay in the treatment which may be fatal.

A rarer complication of epidemic influenza than pneumonia—one, however, which our wards illustrate in a typical manner at present—is pericarditis. Our patient, a man of thirty-eight, had a simple attack of influenza, from which he was decidedly convalescent, when suddenly there appeared, coincident with a rise in temperature from 99° to 101.2°, an evident pericardial friction murmur, to and fro, rough, rasping, and superficial in character, loudest to the left of the mid-sternal line, but loud also at the apex. It was not heard at the base, nor conducted into the axilla. There was evident enlargement of the cardiac area of dullness. A blister was applied, and the next morning the sound had already grown less loud. There was also some pleurisy in the same case. The termination is not always so favorable. A case has occurred in one of our hospitals in which the pericardium was tapped, a purulent fluid removed, and a drainage tube inserted.

## ORIGINAL ARTICLES.

### A FAILURE IN BRAIN SURGERY.

BY HAL C. WYMAN, M.D.,

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JAMES H., a rugged and robust young farmer; father of one child. About a year ago, while digging in the field, he was suddenly attacked with pain in the back of the head. At first supposing it to be merely an ordinary headache, he went to the house and bathed his head with cold water, but the pain continuing severe, he consulted a physician four miles distant, returned home, took the medicine as directed, and was considerably relieved of his suffering. The following day he did not feel strong enough to work, and sent for the physician, who diagnosed malarial fever. The attack lasted about six weeks, during which time he suffered more or less from pain in the head. Becoming dissatisfied with his medical attendant, he sought other advice, which confirmed the original diagnosis of malaria. He took many drugs, but experienced no marked relief from the pain. About four months after the beginning of the attack, he found that his eyesight was failing. He also suffered from nausea and his sleep was disturbed. He vomited a great deal, although the

attacks of vomiting would not come on until some time after taking food, so that he did not lose flesh rapidly. Pain in the frontal region continued persistently. He was then placed upon potassium iodide. This drug for a time seemed to make some impression on his sufferings, and under its influence he was able to secure a few hours' sleep. However, after a few days its effects passed entirely away, and the pain returned with renewed vigor and intensity. He became still more restless and sleepless, vomited more frequently, the symptoms finally culminating in an epileptic seizure. Following this attack of epilepsy, he had divergent squint and additional convulsions, with marked muscular weakness and some fever.

Drugs of every sort were tried in vain, the pain continuing.

Dr. Mere, at my request, made an ophthalmoscopic examination of the eyes and found the condition of the retina indicating pressure upon the optic tract.

**Operation.**—The man became blind or partially blind within a few weeks after the attack of headache. He had had almost no unilateral symptoms, and had but slight movements of rotation, and at times great muscular weakness. These facts led me to locate the disease in the neighborhood of the sella Turcica and in the cerebral ventricle. Therefore, I trephined the frontal bone just above the supra-orbital ridge on the right side. One button of bone was removed, and through the opening the membranes were incised. First, however, the dura mater was raised and a probe pushed along the orbital plate of the frontal bone in the direction of the optic commissure. Then the finger was introduced and the parts carefully explored, but no tumor or abnormality being detected, a small director was pushed cautiously through the anterior lobe of the right cerebrum in the direction of the anterior horn of the right lateral ventricle. But little fluid was evacuated, owing to the brain-substance choking up the instrument. No sensation as of the point of the director free in a cavity was observed. During the administration of the anæsthetic the patient nearly died from failure of respiration. His respiration resembled the Cheyne-Stokes respiration in that his breathing was at times very rapid and then slow. The opening was made at the position designated because the symptoms pointed to disease in the neighborhood of the optic commissure and crura cerebri, and to effusion into the ventricles. A brief recapitulation of the morbid phenomena presented by the case may serve to make clearer my reasons for operating. Pain, quite uniform in quantity and character; fever, of several weeks' duration, immediately after the attack of pain; impairment of sight in both eyes, varying at times in degree; nausea; movements of rotation quite indistinct in the history; general impairment of strength not unilateral.

No incoördination; disturbance of sleep variable; copious nasal discharge and impairment of sense of smell. These led me to think that there was effusion into the ventricles, with disease near the optic commissure and crura cerebri which might be removed by an operation of the kind described. The operation was made in the amphitheatre of the Detroit Emergency Hospital in the presence of the students of the Michigan College of Medicine. Thorough cleanliness was observed in every detail of the work, and the autopsy revealed no evidences of wound infection.

**Autopsy.**—Body moderately emaciated. Wound crescent-shaped on right forehead beginning near the external angle of the orbit, ranging upward and toward the median line of the face until the root of the scalp is reached, then descending to a point midway between the eyebrows. It was closed with nine interrupted sutures and had a plastic exudate between its surfaces.

The general appearance of the body suggested a man of moderately strong physique. His head was well shaped. On removing the calvarium the dura mater was adherent by numerous Pacchionian bodies which had in several places almost perforated the bone. A wound about three-fourths of an inch in length was found in the dura mater over the anterior lobe of the right hemisphere, which corresponded to a hole in the right frontal bone made by the crown of a trephine. Incising the dura and the attachment of the falx cerebri to the crista galli, they were turned back so that the arachnoid and pia mater were exposed. Much fluid was present in the subarachnoid space. There was some ecchymosis of the arachnoid and pia mater near where the dura mater had been divided at the time the bone was trephined. There were also present on the surface of the pia some particles of brain-tissue about the size of grains of wheat.

The membranes were entirely removed, and with a sharp knife a section was made through the right cerebrum on a level with the corpus callosum. This opened the right cerebral ventricle and allowed several ounces of fluid to escape. The left ventricle was opened in the same way, and was found distended with fluid. The third ventricle was then opened by cutting through the corpus callosum and fornix, and was found distended with fluid. The *iter e tertio ad quartum ventriculum* was distended with fluid, so that it easily admitted a lead-pencil into the fourth ventricle. No other changes in the cerebrum were observed, except the shallowness of the spaces between the convolutions. The membranes were now removed and the cerebrum turned back to expose the optic commissure and the tentorium cerebelli, which was divided so that the crura cerebri, pons Varolii, and medulla oblongata could be easily examined. Nothing abnormal was



noticed, except the excess of cerebro-spinal fluid. The optic nerves and commissure were normal. The spinal cord was divided after cutting the cranial nerves, and the entire brain was turned out of the skull. The cerebellum, pons, and medulla appeared normal at first, but looking more carefully at the cerebellum that organ was found to differ markedly in the appearance of its right and left hemispheres. The left hemisphere had a swollen appearance and a peculiar elastic feel which did not exist in the right hemisphere. A cut was made into it to demonstrate the arbor vitæ, when about an ounce of fluid ran out. Separating the cut surfaces, a cavity was found to have been divided which measured one-half inch in one diameter and one inch in another. Within this cavity, which was walled entirely with medullary matter, not a point or streak of gray showing at any point, a tumor oval in shape was found. It was about three-fourths of an inch in its long diameter, and was attached to one side of the cavity by a thick, short pedicle.

#### REMARKS UPON EMPYEMA.<sup>1</sup>

BY MARY PUTNAM JACOBI, M.D.,  
OF NEW YORK.

(Continued from page 122.)

THE little boy, whose case forms the text of this paper, as soon as the diagnosis of empyema had been confirmed by the hypodermic syringe, was etherized, laid upon the affected side, and an incision made in the eighth intercostal space in the posterior axillary line. The operation was rendered a little more difficult by the position given to the child. But this inconvenience was held to be compensated by the advantage of securing to the sound lung entire freedom from compression. The incision through the skin was a little less than an inch in length, and was made layer by layer until the pleura was nearly reached, when a trocar was plunged in, and its opening subsequently enlarged until it would admit a drainage-tube the size of my finger. This could just be squeezed through the space between the ribs, which, as always in a young child, was narrow.

On account of this narrowness, which has frequently been recognized as a source of difficulty, it did not seem that anything would be gained by making a longer incision, unless, as in Dr. Cabot's method, two drainage-tubes were to be inserted.

The size of the opening which should be made in the chest, in order to evacuate a purulent effusion, has been the subject of animated controversy.

It seems scarcely necessary to reopen the discussion in regard to aspiration of the chest in empyema. The discussion of the New York Academy

of Medicine, held in 1887, resulted in the unequivocal condemnation of aspiration for purulent effusion, and in the recommendation of antiseptic incision as a method which, as Dr. Holt remarked, has changed empyema in children from being one of the most fatal to one of the most amenable of diseases. But it is both interesting and surprising to note how very recently this method has been definitely acquired. Guibert, in 1875,<sup>1</sup> relates with complacency the case of a boy of eleven, under treatment for nine months, and subjected to seventy-four punctures with Dieulafoy's aspirator. In 1862 Ziemssen, quoted by Schenks, said that operation was rarely needed for empyema in children. In the great majority of cases in which aspiration has been tried, the continued recurrence and aggravation of all morbid conditions decided the physicians to resort to incision, with drainage. Dr. Holt has collected 121 cases treated by aspiration, of which 6 died; 23, or nineteen per cent., were cured; the rest came to treatment by incision. Yet in the International Congress of 1881, although Ranke and Gerhardt advocated free incision, Baginsky advised delay, to see if the pus might not be removed by expectoration. Robert Lee and Parker, of London, advocated repeated aspiration, and Dr. Jacobi reported three cases of empyema in children, observed in one year, who had been radically cured by aspiration.<sup>2</sup>

Some years ago I treated by aspiration a case of empyema in a child of eighteen months, and the child died.<sup>3</sup> The dangers of aspiration are not

<sup>1</sup> *Lyon Médical*, November, 1875, quoted by Bouveret.

<sup>2</sup> Esch, *N. Y. Med. Record*, 1887, relates a case of empyema in a boy eight years old. Twelve ounces of pus were withdrawn from the pleura by aspiration, and, after a temporary improvement, the refilling of the chest necessitated repetition of the aspiration seven times in the course of a few weeks. Each time, eight to fourteen ounces of pus were withdrawn. The child had chills, and a temperature ranging from 102° to 104°. Finally, Esch injected through the aspirating needle eight ounces of a two per cent. solution of bicarbonate of soda, and withdrew in ten minutes. Speedy recovery.

Leichtenstern, in Gerhardt's *Cyclopædia*, says that it is unquestionable that empyema may be cured by repeated puncture and aspiration, like any other abscess. In 1871, Bouchert (*Gaz. des Hôp.*, 1871) proposed to treat infantile empyema exclusively by this method.

Branthomme's thesis contains eighteen cases cured by single aspiration.

Bouveret quotes forty-three from the thesis of Branthomme, divided into four groups. In the first group of 18 cases, a single aspiration sufficed to cure. In the second group of 11 cases, the aspiration was practised twice—the recovery equally prompt. In the third group of 3 cases, there were three aspirations, and speedy recovery. Finally, in a fourth group of 11 cases the number of aspirations ranged from 6 to 122.

<sup>3</sup> Schenker (*Jahrb. für Kinderheilk.*, N. F., 1883, Bd. xx.) relates fifteen cases, of which six were treated at first by aspiration. Of these one died after a second aspiration. The others were treated by incision and drainage.

Goodhart (*Guy's Hosp. Rep.*, 1877) reports two cases of aspiration, both of whom died.

<sup>1</sup> Read before the New York Academy of Medicine, Section on Pædiatrics, November, 1889.



purely negative and dependent on delay in relieving the organism of its collection of pus, and lungs and heart of the mechanical impediments offered to their functions; but, unless the disinfection of the aspirating needle is perfect, and it often is not, there is the same danger in plunging it into a closed pleural effusion as has been so often noted in the hypodermic exploration or aspiration of abdominal cysts, and of which I have myself reported two observations. If germs are carried into a cavity with a free opening, and from which a current of fluid is constantly flowing, they have at least a large proportion of chances of being washed away. But, introduced into an hermetically closed cavity, no such chance is offered, and infection is unavoidable. This danger does not seem to have been emphasized by authorities as distinctly as the fact of the almost inevitable recurrence of the effusion after the most complete aspiration, and the great probability that the aspiration in every case must remain incomplete. Other more exceptional dangers of aspiration, empyema shares in common with serous effusions; the dangers of albuminous expectoration, pulmonary oedema, and other accidents liable to occur when a lung, bound down by adhesions, is drawn upon by a powerful aspirating machine. These dangers are, of course, more rare in children, precisely because in them the lung is usually movable. The prejudice in favor of aspiration dates from the epoch when incisions were made without any antiseptic precautions. We now know that many of the dangers then attributed to the introduction of air were really due to infection of the wound or of the suppurating cavity. But it is again surprising how recent is this discovery, and indeed how long a time elapsed after the establishment of the Lister method elsewhere, before it was applied to the treatment of empyema: according to Bouveret,<sup>1</sup> the very first case in which pleurotomy was performed for empyema with antiseptic precautions occurred in Calcutta, under the care of an English surgeon, Ewart, and was reported by him in 1873.<sup>2</sup> In 1877, Goodhart speaks despairingly of the conflict of opinion in regard to the treatment of empyema; says that the incision treatment gives a mortality of 33 per cent., and is not more favorable than Playfair's method of subaqueous drainage. "This," he observes, "is simplicity itself, and looks, at first sight, almost perfect. I do not know that even now I am prepared to say that any other method of treating empyema is better, but, after treating several cases and seeing others treated, I think if no other treatment can be made to give better results than it, empyema will remain a most fatal disease, with the chances for or against the patient's life about even."<sup>3</sup>

In 1880, Dr. Cabot commented on the slow progress made by the antiseptic method in regard to the treatment of empyema, and attributed it in part to the tenacious belief of physicians that in aspiration they have a means of curing the patient with less risk, hence do not trouble themselves to master the methods by which incision may be stripped of its risks. At this date Dr. Cabot could find reports of but ten cases treated antiseptically, all in German; namely, four by Wagner,<sup>1</sup> four by Goeschel,<sup>2</sup> and two by Krabbel.

To-day, the cases of antiseptic pleurotomy have multiplied so considerably, that it would be useless to quote them in a paper like the present. I will again, therefore, simply refer to Dr. Holt's statistics of 63 cases, with 61 recoveries and 2 deaths. The statistics of Cabot and Eddison, reproduced in 1888 by Bouveret, of 40 cases of non-tuberculous empyema in adults, give 34 complete cures, 2 permanent fistulae and 4 deaths.<sup>3</sup> The case which forms the basis of this paper is the sixth I have treated, and with success. My friend Dr. Annie Daniel also reports six cases where antiseptic drainage treatment was followed by complete recovery. There can be no doubt, therefore, that the pendulum of chances has swung over so considerably during the last decade, that, with incision and drainage treatment, recovery of children from empyema should be considered the rule—death the exception.

There are, however, four details of the treatment that are not so well settled. These are, the use of the spray, the size of the opening to be made in the chest wall, if puncture and aspiration be excluded; the employment of irrigations, and the use of a valve in the dressing. When, in 1873, far away in Calcutta, the antiseptic method was, as it would appear, first applied to the empyema operation, the incision and subsequent dressings were rigorously guarded by the spray. For a long time the spray was considered indispensable; and as late as 1888, Bouveret, while admitting the superfluity of the spray for other surgical operations, insists upon re-

<sup>1</sup> Volkmann's klinische Sammlung, No. 197. Also Berlin. klin. Wochen., 1878.

<sup>2</sup> Berlin. klin. Wochen., 1878.

<sup>3</sup> Among reported cases of successful pleurotomy may be cited: Goeschel: Loc. cit., four cases, four recoveries (young children).

Phelps (N. Y. Record, 1880): fourteen mixed cases, eleven recoveries, three deaths.

Lindner: Jahrb. für kinderkrank., N. F., Bd. xvii., one case recovered—seven months' child.

Skerrett (Brit. Med. Journ., 1876): one case, recovered.

Cabot (N. Y. Med. Journ., 1880): seven cases, children, all recovered rapidly.

Redenbacher (Deutsch. Archiv. für klin. Medicin, Bd. ix.): one case, recovery in fourteen days.

Huber (Archives of Paediatrics, Nov. 1889): two cases, double empyema, recovery.

<sup>1</sup> Traité de l'Empyème, 1888, Paris et Lyon.

<sup>2</sup> Lancet, 1873.

<sup>3</sup> Loc. cit.

taining it in treatment of empyema. The spray was used by Skerritt<sup>1</sup> in 1876, by Koenig and Wagner in 1878,<sup>2</sup> but the latter does not consider it necessary, and the former claims always to resect a rib. The spray is uniformly advised by Douglas Powell,<sup>3</sup> and by Bennett in Ashhurst's *Cyclopædia of Surgery*. It was strenuously insisted upon by Dr. Cabot in 1880,<sup>4</sup> by Leamoine in 1880, and is advised by Donaldson, writing in Pepper's *System of Medicine*, whenever an incision is made six centimetres long. It is considered superfluous if the incision only passes through the skin and muscles, and the pleura itself is opened by a trocar. In the Academy discussion of 1887, Dr. Abbe advised the spray, but this was not mentioned by any other speaker, nor in the discussion at Washington last September over Dr. Huber's two remarkable cases of double empyema. Dr. Gerster, in his treatise on antiseptic surgery, expressly condemns the spray as an objectionable feature for empyema as for other operations.

In the case of the little boy here described, no spray was used, and recovery was complete—i. e., the tube was withdrawn on the thirty-second day. In my five other cases, however, the duration of treatment was about two months. In Dr. Daniel's six cases the spray was also omitted, but other antiseptic precautions were used. The trocar and drainage-tube employed had been kept in pure carbolic acid during the twenty-four hours preceding the operation.

Of these six cases one died suddenly on the third day, twenty-four hours after an erysipelatous inflammation around the wound had been noted. In the five other cases the tube was removed on the thirteenth, nineteenth, twenty-third, twenty-eighth, and thirty-third days respectively.]

While the fluid is running out from the incised chest no air can enter. The entrance of air is signalled by a loud suction noise, and takes place at the moment that the abnormal positive tension in the pleural cavity, due to the presence of the fluid, is changed to a negative tension by its evacuation. It is quite possible, if the contents be perfectly fluid, to place a thick layer of antiseptic gauze over the opening at the moment the flow begins to slacken. By this means any air drawn into the chest will be filtered. This would even be possible when, through a large opening, semi-solid masses of fibrin and clots were being expelled by coughing.

It is generally admitted now that infection of

wounds does not proceed from germs floating in the air, but attached to instruments and other solid bodies. Further, the experiments of Stimson, confirmed by Cabot himself, who so strenuously recommends the spray, show that air which has passed through spray continues to infect culture tubes; on the other hand, methods of operation which effectually exclude air, as the subaqueous drainage, and the guarded trocar of Reybaud, were very often followed by fever and other signs of sepsis, often fatal. On one day when I operated by the trocar on a child at the Mount Sinai Dispensary, another child of the same age was admitted to the wards and submitted to subaqueous drainage. The dispensary case, though brought from a distance three times a week, recovered, after some vicissitudes, in two months. The hospital case died of exhaustion after three.

In cases where air has been thoroughly excluded from the pleura opportunity remains for infection of the external wound; and this opportunity recurs with every change of the dressings. Constant irrigation of the lips of the wound during the dressing is a much more potent method of averting infection than is the spray.

The size of the incision seems to have been regulated according as the operators were more preoccupied with freeing the pleural cavity from pus, or with facilitating the reëxpansion of the collapsed lung. It is under the influence of the first idea that König and Demme have advised the resection of a rib for, at least, all adult cases; that directions are given for incisions six centimetres long, and that stress is laid upon placing the incision as low as possible. Certainly, for children at least, too many cases are now on record of cure by simple incision to allow us to consider resection as anything but an exceptional expedient. Further, so long as the contents of the pleura are entirely fluid, it is difficult to see why they will be evacuated any more easily through an opening of six centimetres than through a tube the thickness of a finger. The tube is only inadequate if there are solid coagula too large to pass easily through it. Similarly, it seems to me extremely doubtful whether the situation of the tube at a lower portion of the chest is more favorable to the outflow than a higher position. In a case of empyema that I saw in consultation with Dr. Daniel, the pointing was under the right clavicle, and here the opening was made. Drainage was perfect; and this is always the experience with spontaneous openings of empyema. The fact that these openings occur in the upper parts of the chest at least as often as lower down, is itself a proof that the contents of the pleural cavity may be pushed toward any point on the circumference, and do not follow the laws of gravity. The familiar experience of the straight glass drainage-tube which is so often plunged into

<sup>1</sup> Brit. Med. Journ., 1876.

<sup>2</sup> Berliner klin. Wochens., 1878.

<sup>3</sup> Diseases of Lungs and Pleura.

<sup>4</sup> N. Y. Med. Journ., 1880. See also Neurbe-Fraentzel, in Ziemssen.

The spray was used in all the forty-one cases, including fourteen cases of children, in the statistics compiled by Bouveret.

the peritoneal cavity after laparotomy operations, shows that the pressure of the closed cavities of the living body is capable of forcing fluids upward as well as downward. In the empyema operations the perforated drainage-tube generally passes upward; it certainly did so in the case of Frank. But the circumstance did in nowise interfere with the drainage.

The forces which expel the fluid from the pleura are: 1. The positive tension existing in the cavity, and which, to the great detriment of the patient, has replaced the negative tension which is normal. 2. The reëxpansion of the lung, which should begin as soon as this positive tension is lessened. This is illustrated in the balloon and flask. 3. The respiratory movements—those of inspiration as well as those of expiration. During inspiration, when the chest-wall moves outward and enlarges the pleural cavity, all the contents of the cavity must move forward in the direction of the least resistance. Unless the opening be occluded, the lung will not so move, because the internal atmospheric pressure which should keep out the walls of its cavities, is neutralized by air on the other side, and is, therefore, inoperative. But if there be fluid in the cavity, its pressure exceeds both that of the air within and of the air without; and when compelled to move, it moves forward toward the point of least resistance—*i. e.*, the fistulous opening toward the external air.

For these reasons it is difficult to see any advantage in a very large opening; provided, of course, that the flow of liquid continues perfectly unobstructed.

The gradual contraction of the pus cavity, effected through the approximation of the pleural surfaces, can hardly be counted among the expelling forces. Certainly a most important condition for the formation of such adhesion is the persistent evacuation of the pus as fast as it forms. In the case of Frank, as the flow of pus through the canula began to slacken, an antiseptic pad was laid over the opening—not, however, before air was twice drawn into the pleura with the usual suction noise. The respiration was considerably accelerated at the moment of opening the pleura, and for some moments afterward, the inspiration becoming deeper. The same change in respirations is observed when a closed tube, communicating only with a manometer, is plunged into the healthy pleura of a dog. The change seems due entirely to the greater exertions made by the sound lung, but implies a direct transmission of impressions from the wounded pleura to the inspiratory centre in the medulla.

In the boy Frank the opening made by the trocar was enlarged by the bistoury until it would easily admit the drainage-tube; this was inserted, and secured by a safety-pin packed around with iodo-

form gauze, after the lips of the wound had been thickly powdered with iodoform, and while the pus was still running from the tube, an antiseptic dressing was applied without previous irrigation of the pleural cavity.

The question of irrigations into the pus cavity—primary or consecutive—has been strenuously debated. When advised, it is with the intention: 1. Of thoroughly removing all pus from the pleura, so that none may remain to decompose. 2. Of disinfecting the pleural cavity of germs which, in spite of all previous precautions, may have been carried into it.

Now this second reason can have no weight, if the antiseptic precautions previously taken have any real efficiency. As to the first reason, the records of cases prove that pus reaccumulates in the twenty-four or forty-eight hours following the operation in amount sufficient to necessitate a change of the dressings, and this, whether irrigation has been practised or not. Nevertheless, many of the writers who use primary irrigation, as Cabot, do not repeat the washing on account of this reaccumulation, but simply renew the dressings. If the irrigation be not needed the second time, it is difficult to see why, for the purpose of removing the pus, it should be required the first time.

The amount of pus that is poured out in the first day or two after the operation is often astonishing. In the case of Frank—where, at the first dressing, thick layers of cotton wool were used instead of, as subsequently, oakum—the dressing, clothes and even bedding were saturated. It is true the evacuation of pus had not been quite complete at the operation; but there could not have been much fluid in the pleura, for, before applying the dressing, I ascertained that almost normal percussion resonance extended all over the back of the chest. The abundant discharge, therefore, of the first day must have been due to a new formation or effusion of pus; and it is comprehensible that the removal of pressure from the pleural surfaces may facilitate an abundant emigration of leucocytes from the distended capillaries and lymph spaces of the pleural tissue.

In a perfectly normal progress of events, when the later or secondary elimination has been effected, the discharge from the drainage-tube should rapidly diminish and cease. Bouveret relates one case of complete cure in nine days, the shortest on record. Many cases are on record where the tube could be removed in twenty or fifteen days, or even less. In Ewart's pioneer case, an adult, the discharge is said to have become serous in six days. Two circumstances thwart this normal progress: the suppurating surface may become infected, or the pleural inflammation which gave rise to the suppuration may persist as suppurative, instead of retrograd-



ing to an adhesive form. In either case, the child will have fever, and the discharge will remain offensive. In either case, irrigation becomes indicated, and, if practised, will be followed by a fall of temperature.

It is certain that thousands of irrigations have been practised which only serve to keep up the irritation they were intended to allay. This is especially the case with carbolic acid irrigation, of either one, two, or three per cent. The danger of poisoning is very considerable; but, apart from that, the danger of irritating the inflamed tissue of the pleura is more uniformly present. Cases treated by carbolic acid irrigation have been described complacently as sustaining a treatment of three months, which, in a non-complicated case, itself impugns the treatment. In two of my own cases, one per cent. solution of carbolic acid was used for irrigation when the temperature rose; but the child became restless, as from pain, and the temperature rose higher. Irrigation with a solution of bichloride 1:6000 was substituted, and the temperature fell, not again to rise.

Out of the five cases reported by Dr. Daniel only one was irrigated. The irrigation was made daily with a two per cent. solution of carbolic acid, for a period of nineteen days, yet the fever continued with little abatement. It is evident that, apart from the irritation of the inflamed pleura, repeated irrigations tend to thwart the two essential parts of the healing process. Each tends to break down the delicate adhesions forming between the pleura, and to oppose the reexpansion of the lung. No one can deny their utility when pus is found foetid at the time of the operation, or if it become so afterward, for it is important to remove fetid pus or gangrenous masses at once, and not trust to their gradual elimination. But there is no proof that it is important to remove fluid and laudable pus at once, but only to provide for its free, steady, and uninterrupted gradual evacuation. As soon as the internal tension of the pleural cavity has been relieved by removal of such excess of fluid as spurts with force through the drainage-tube, and as soon as drainage is instituted and maintained, tendencies to absorption of pus are arrested and the lung is enabled to reexpand. If the pleural cavity were empty of fluid, but, from imperfect collapse of its walls, filled with air at ordinary atmospheric pressure, expansion of the lung would be retarded as much as in the presence of fluid. This is sufficiently demonstrated by the accident of pneumothorax. There is really no advantage in removing the pus faster than the lung can follow its retreat, and the contact of the pleural surfaces be effected.

In my case, no irrigation was made at the time of the operation. The next day, the rectal tempera-

ture, which had been 104° on the afternoon of the operation, had fallen to normal; the dressings were saturated, and were removed. During removal, air was twice, but only twice, sucked into the pleura. During the next week I did not see the child, but the dressings were changed every two days by another physician. The temperature, taken in the mouth, was reported as normal during the week, but the cough was severe, while it had been scarcely perceptible before. On the seventh day I saw the child again, and found the rectal temperature 101½°. The percussion resonance over the lung was nearly normal, the breath sounds harsh and bronchial without vesicular murmur; the heart was in place. In changing the dressing this time, the cotton wool outside the antiseptic gauze was replaced by oakum. Before replacing the dressing, air was again drawn into the chest with a loud noise. Again I did not see the child for four days, during which, however, the dressing was twice changed by the other physician. On the eleventh day after the operation, I found the rectal temperature 103°, the child coughing much, still pale and languid, complaining much of pain in the chest. On this occasion, and for the first time, I irrigated from a fountain syringe with a warm solution of corrosive sublimate, containing 1:6000. On this occasion, no air was drawn into the chest. Two other changes were also made in the treatment: a valve of rubber tissue, hitherto imperfectly applied, was accurately adjusted over the fistula, and antipyrin was given in five-grain doses every three hours. Three effects were observed: The temperature fell permanently after seven doses of the antipyrin had been taken. The discharge lessened so much that the dressing remained untouched for a week, and was then found scarcely soiled. The cough lessened, the child became lively and free from pain, and a week after the irrigation, eighteen days after the operation, was found running about, eating well, and appearing quite well. The dressing was replaced, left a week longer, when the fistula was found to be granulating abundantly, the discharge entirely trivial. It is possible that the tube might then have been removed; it was evident that the pleural cavity had contracted to a sinus around the tube. For greater security, the tube was simply shortened, and only entirely removed a week later, on the thirty-second day after the operation. The fistula closed immediately.

On the eleventh day, when irrigation was performed, the character of the discharge had changed—become slightly sanious, with a few small fibrinous coagula. But there was no evidence of their decomposition, nor of septic infection of the wound, although on several occasions the dressings had been too loosely applied, and the antisepsis imperfect. The fever, pain, and cough seemed to have been

kept up by the continued inflammation of the pleura, and it is this which seemed to subside promptly under the combined influence of the bichloride irrigation, the valve, and the antipyrin.

(To be concluded.)

### HERPES PROGENITALIS.<sup>1</sup>

BY G. FRANK LYDSTON, M.D.,  
OF CHICAGO, ILL.

HERPES progenitalis is an important, though relatively harmless, disease. Its importance depends chiefly upon its frequent occurrence, the greater or less amount of local irritation which it sometimes produces, and its demoralizing effect upon the mind of the patient. As is well known, it consists of a development of small vesicles filled with a watery, sometimes sero-purulent, fluid upon the skin or mucous membrane of the genitals. It is rarely seen in the female, although in Hebra's *Atlas* there is an excellent representation of the disease as occurring in a woman. According to Unna, the disease is not so very infrequent in women—this accords with my own experience.<sup>2</sup> Dr. Duhring states that he has never seen a single case in women. It is possible, as Unna says, that women are as susceptible to herpes as men, and if this be true, the reason for its apparent rarity must be the protected situation of the lesions which prevents their being readily discovered.

According to Legendre, Fournier, and Bruno, the coincidence of an herpetic eruption with menstruation is by no means infrequent, and in some women it comes on two or three days prior to each menstrual epoch. My experience is limited to a single case in which a lady suffers considerably at each menstrual period from a crop of herpetic vesicles and ulcerations about the inferior commissure of the vulva. They are very annoying from the pain and smarting which attend them, the act of urination being particularly distressing. With some attacks there occurs marked oedema of the genitals.<sup>3</sup>

The diagnosis of herpes progenitalis is, in uncomplicated cases, comparatively easy. There is in most cases a history of recurrent crops of vesicles and minute ulcerations perhaps independent of sexual intercourse. There will be no definite relation in the large proportion of cases to any particular act of intercourse—even when due to irritating materials deposited upon the mucous membrane during un-

cleanly coition the affection follows at variable intervals, in some instances the eruption appearing within a day or two, and in others not until the lapse of as many weeks. When the lesions have become ulcerated a diagnosis is often difficult.

The cause of herpes is usually said to be local irritation, but I am convinced, from personal observation, that by far the greater majority of cases are dependent upon a neurosis—the disease in this respect strongly resembling herpes zoster. Some patients of a highly irritable, nervous temperament, who are readily subject to nervous depression, and who perhaps suffer from more or less general debility, are affected at variable intervals with successive attacks. Malarial infection may produce herpes progenitalis as well as herpes in other situations. Unna is inclined to regard the disease as a rudimentary form of herpes zoster, and calls attention to the limitation of herpes zoster and herpes progenitalis to the peripheral points of distribution of nerves. The same author gives as other causes of herpes a disturbance of the parts incidental to pregnancy and menstruation in the female; uncleanliness, decomposing secretions, hot weather, obesity, forcible attempts at intercourse, impeded erection due to redundant prepuce, excessive venery, and masturbation; these various causes giving rise to excessive congestion of the genital organs, which the author believes to be the essential condition upon which herpes progenitalis depends. Imperfect or perverted sexual hygiene is peculiarly apt to give rise to more or less congestion of the genitalia with attendant disturbance of the delicate nerves supplied to these parts. That this condition of affairs may give rise to trophic changes in the mucous membrane and skin, as evidenced by the occurrence primarily of vesicles and secondarily of ulceration, is highly probable.<sup>1</sup>

There has been, so far as I am aware, no mention made by any of our numerous writers of the possible causal relation of syphilis to herpes progenitalis. I am convinced, however, from practical observation and experience, that many cases are directly dependent upon the syphilitic cachexia. I find quite a number of my syphilitic patients returning to me from time to time, with apparently typical crops of herpes upon the genitalia, which are obstinate to all local measures excepting the application of mercurials. Tonic and mild anti-syphilitic remedies are also required internally. I attribute the herpes in such cases to several causes:

First. (In some cases) local irritability incident to a pronounced chancre or mixed sore which has initiated the patient in his venereal trouble.

<sup>1</sup> I have under observation the case of a lady in whom herpes progenitalis develops coincidently with pregnancy; indeed, she regards the herpes as pathognomonic of pregnancy.

<sup>1</sup> Read before the North Texas Medical Association, December 12, 1889, at Gainesville, Texas.

<sup>2</sup> Journal of Cutaneous and Venereal Diseases, August, 1883.

<sup>3</sup> An interesting case of herpes, apparently dependent upon menstruation, recently came under my observation, in which the eruption instead of being located upon the genitals appears between the fingers. It comes on a few days prior to menstruation, and lasts for a day or two after its cessation. During this time considerable neuralgic pain in the arm and hand is complained of.

Second. Disturbed innervation and consequent trophic changes, incidental to the effects of the syphilitic poison, excessive medication (especially with mercury) and mental worry, upon the sympathetic system.

In regard to the areas involved by herpes progenitalis, Unna states that it rarely affects the integument of the penis, scrotum, or thighs, being limited usually to the glans penis. He also states that the eruption almost invariably corresponds with the course "of the ramus dorsalis penis," a branch of the pudic nerve. As far as my own personal experience goes, I have not noted any regularity of distribution of the herpetic vesicles, and I have seen a number of cases of the disease which were limited to the skin of the organ. The pain of herpes progenitalis is usually insignificant; however, if urine be brought in contact with the small ulcerations left after the rupture of the vesicles, the part becomes exceedingly tender and much burning and smarting are complained of. The disease is apt to occur about the borders of the meatus urinarius and occasionally just within the lips. I have one patient in whom a row of some half dozen small herpetic vesicles develops upon the right side of the meatus from time to time, and another in whom there is an occasional development of herpetic spots just within the orifice of the urethra. In such cases there is considerable pain and smarting during urination, and the disease seems to develop coincidentally with nervous depression.

The two diseases for which herpes may be mistaken are chancre and chancroid. There is, of course, no difficulty in the differential diagnosis of herpes from typical chancre and chancroid when these diseases are fully developed, but in the incipient stages of these affections a mistake is very apt to occur. Fortunately, however, a few days' study of the case will generally clear up the diagnosis. Chancroid often begins as a small herpetiform vesicle or perhaps a group of vesicles or ulcers. This is probably due to the fact that the chancroidal virus or perhaps some other irritating material to which the parts are exposed during intercourse, produces herpes by simple irritation; chancroid developing at the site of the herpetic lesions at a variable period of time thereafter. The same explanation is true of some cases of hard chancre. The "herpetiform chancre" described by French writers is probably explained in this way. Unna has noticed a form of sore which is probably the so-called herpetiform chancre. With reference to this point, he says:

"I know only two affections which, because of their form and rarity, may be mistaken for herpes progenitalis, but only during the first few days of their existence. Chancres in the male now and then occur on the inner surface of the prepuce, are benign in their ap-

pearance, and slowly involve the surrounding tissues, and these at first sight look like herpetic erosions. They are the chancres of Tyson's glands which develop as inconsiderable epithelial proliferations in small contiguous groups of sebaceous glands—usually a group of from four to six neighboring glands are attacked. The round follicular openings are eroded, abnormally patulous and acutely hyperæmic, so as to give the impression of an herpetic erosion. If a simple dusting powder is prescribed for this affection, the case drags on and the typical herpetic course being followed, slight periglandular induration becomes manifest, succeeded by glandular disintegration and confluent, rapidly spreading ulceration, all of which impress the physician that he is dealing with a soft chancre, the course of which was protracted by its unusual seat. These exceptional cases, from the favorable prognosis they may elicit, are apt to discredit the physician's ability."

In the cases in which true syphilis follows an apparently herpetiform lesion of the genitalia, there will probably always be found upon close inspection, if the case be carefully watched from day to day, a greater or less degree of chancroidal induration.

One of the reasons for the confusion that exists in the minds of physicians regarding the relation of certain atypical genital lesions to constitutional syphilis, is that they do not watch their cases with sufficient care and are prone to give a pronounced opinion in regard to the prognosis of such lesions without due consideration of the many sources of error. If these cases were more carefully studied, it is highly probable that the ranks of the dualists would be sadly depleted and many of those cases of syphilis which have apparently followed simple, non-indurated lesions of a herpetic, ulcerative, or chancroidal character, would be found to have been preceded by induration of greater or less degree which developed after the simple sore had apparently healed, and at a time when the patient's attention was no longer directed to the local difficulty. Again, as will be seen when we come to the consideration of the diagnosis of syphilis, induration may appear and disappear within a short time and its presence escape attention, unless the case be watched with extreme care from day to day.

When herpetic ulcerations become inflamed they are apt to assume physical characters strongly resembling those of true chancroid. Indeed, I am of the opinion that under favorable circumstances herpetic and balanitic ulcerations, or, for that matter, ulcerations of any sort whatsoever, may become transformed into a mild type of chancroid. I make this statement with a full appreciation of the wide clinical differences which exist between typical herpes and typical chancroid. I will, at this point, interpose a word of caution: Never give a positive opinion upon the character of herpes progenitalis, or, indeed, upon any apparently non-specific lesion of the genitalia in cases in which there has been a suspicious exposure within a suffi-



ciently recent date, without stating plainly to the patient the possibility of there having been a syphilitic or chancroidal infection which will develop sooner or later, and which the physician has no means of detecting prior to the appearance of the specific sore.

The treatment of herpes progeneralis is, in the majority of instances, sufficiently simple, but in a certain proportion of cases the disease is very obstinate. Simple dusting powders or astringent washes are all that is required in the way of local measures, as a rule. The powder which I have found to be most efficient is the preparation of oleate of zinc prepared by Parke, Davis & Co. Other preparations I have found to be unreliable, as they tend to become lumpy, and, consequently, produce irritation. Calomel, oxide of zinc, subnitrate and subcarbonate of bismuth, and lycopodium, singly or in various combinations, are useful. A simple astringent wash of iodide of zinc, five or ten grains to the ounce, or alum, in a strength of twenty or thirty grains to the ounce, may be used as a lotion. It may be necessary to touch the herpetic spots with nitrate of silver. When the lesions are very painful, morphine or cocaine may be added to the dusting powder. The essential point in the treatment is to keep the parts clean and dry. In some instances circumcision is advisable. In quite a number of cases it will be found necessary to adopt constitutional as well as local measures: tonics, such as quinine, iron, and strychnine, and where there is much nervous irritability, bromide of potassium, are indicated. In some very chronic cases, arsenic will be found to produce excellent results.

In the solitary case of menstrual herpes which I have seen, the bromides, with very small doses of ergot for a week or ten days prior to the menstrual period, have proved of some benefit, although the patient is still troubled more or less. In some cases of genital herpes in the male the occasional passage of a sound will prove beneficial as tending to relieve nervous irritability and congestion, to allay sexual excitability and, in a general way, improve the tone of the genital organs. I have seen a few obstinate cases which were apparently cured by matrimony. A few cases will be found to be absolutely resistant to treatment, but may at any time recover spontaneously.

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### THE MANAGEMENT OF BLEPHARITIS.<sup>1</sup>

BY H. GRADLE, M.D.,  
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ACCORDING to some of the popular text-books on diseases of the eye, the inflammation of the margin

of the lids would seem to be a very easily remedied affection. Anyone, however, who has had extensive personal experience will readily grant that such is not the case, and that the disease is very often rebellious, at least under the routine treatment most commonly advised. As this routine treatment—viz., the use of some mercurial preparation in the form of a salve—has proven neither the quickest nor the most reliable in my hands, I wish to offer some therapeutic suggestions based on my own experience.

We can distinguish clinically two forms of blepharitis, viz., the *ulcerative*, and the *non-ulcerative* or *squamous* inflammation of the palpebral margin. The former may be closely compared to eczema as seen on the scalp, while the scaly form of blepharitis resembles that affection of the scalp known as dandruff or seborrhœa, also described by Michelson in Ziemssen's *Cyclopædia* as alopecia pityrodes. It is difficult to say from clinical evidence alone whether these two forms represent different stages of the same disease, or are separate and distinct processes. The latter seems to me to be the more probable view. One of the reasons pointing toward this view is the fact that the squamous form invariably affects both eyes, while ulcerative blepharitis may be limited to one side. It is true, on the other hand, that something like transitional forms are occasionally met with. Sometimes small ulcers occur in the squamous form; but occasionally, too, one may find an abrasion of the scalp under a thick scale of dandruff. After the ulcers of the ulcerative form have been healed, the edge of the lid may remain inflamed for a while, but in that case it scarcely presents the scaliness of the typical squamous blepharitis.

Fukula claims that anatomically *blepharitis ulcerosa* is a disease of the papillary layer of the skin, while the squamous form of disease is located in the glands.

We are no better informed as to the causes of blepharitis than as to the etiology of the corresponding diseases of the skin in other parts. In the fresh pustules of the ulcerative form, Widmark has found the pus staphylococci. These undoubtedly cause the suppuration, but whether this is a complication or the cause of the disease is as yet undecided.

We do know, however, of certain predisposing influences which must be borne in mind in the successful treatment of this disease. Two of these conditions are commonly known to oculists, while the third has as yet received less general attention. The first of these is insufficiency of the lachrymal passages. Stricture of the duct or mere inflammatory stenosis, and especially inflammation of the tear-sac, may be the condition which favors the occurrence of the disease as well as the obstacle to the cure of blepharitis, particularly the ulcerative form. It

<sup>1</sup> Read before the Chicago Medical Society, January 20, 1890.

has further been pointed out by various oculists that eye-strain due to hypermetropia or astigmatism often favors the persistence of blepharitis, and may require correction by glasses before the inflammation of the lid can be removed by local treatment. A third condition which my experience has often taught me to recognize as a factor in the production of blepharitis is nasal disease. The mere coexistence of nasal anomalies and blepharitis would not prove the causal relation of the former, in view of the great frequency of morbid processes in the nose. I have, however, seen, a number of times, that nasal treatment alone improved and gradually cured a blepharitis which by itself had annoyed the patient so little that he had not sought my advice for the affection of the lids, but only for the nasal difficulty. On the other hand, I have occasionally met with cases of blepharitis, more especially the ulcerative form, in which I could not succeed in curing the patient permanently until I had turned my attention to the nasal cavity. I do maintain, however, that even in those cases where the nasal affection is presumably the influence which favors the occurrence of the disease and tends to perpetuate it, blepharitis can often, though not always, be cured by local means without removing the nasal anomaly. Hence I consider nasal anomalies not the exciting cause of blepharitis, but merely a predisposing condition. In view of the very many coincidences of blepharitis and nasal disease which I have seen, I believe this predisposing influence to be a frequent one. Predisposing nasal disease may be any form of nasal disturbance or anomaly as well as blockage of the post-nasal space by adenoid vegetations. The mode in which nasal anomalies influence the lids is probably by creating disturbances in the venous circulation. In some instances besides, nasal disease leads to lachrymation and insufficiency of the lachrymal passages.

Fuchs<sup>1</sup> has called attention to another cause, or rather predisposing condition in occasional instances of blepharitis, viz., insufficient length of the skin of the upper lid, causing a slight gaping of the lid-aperture during sleep.

In the treatment of the ulcerative form of blepharitis, I can only endorse the majority of authors as to the use of the nitrate of silver stick. Its thorough application to the ulcers after removing the adherent crusts will stop the process sometimes at once, at other times after a few repetitions. The non-ulcerative inflammations which may still persist can then be made to yield by the use of an oxide of zinc salve. The latter has seemed to me to be more efficacious with the addition to it of about 5 per cent. of ich-

thylol. In other instances, I have succeeded well with pyrogallic acid, one part to eight of vaseline. I have seen either of these remedies succeed where mercurial ointments failed. It is well to remove with forceps all loose cilia in addition to this treatment.

The squamous form of blepharitis does not always yield to mercurial ointments, be it the white or the yellow precipitate, or the nitrate of mercury. It is necessary to remove in any case the scales which sometimes form very quickly. I have found that a 5 per cent. solution of chloral carefully applied with the finger to the edge of the lid facilitates the removal of the scales and may by itself cure the disease. A quicker treatment is the application of a pyrogallic acid ointment, which it is well to tell the patient may stain the skin temporarily.

Much quicker and more satisfactory results, however, I have been able to obtain by a treatment suggested to me by my dermatological friend, Dr. Zeissler, on the ground of the analogy between squamous blepharitis and seborrhoea of the scalp. This consists in the use of sulphur ointment, which I have never seen mentioned in ophthalmic literature. I have usually employed a 3 per cent. mixture of milk of sulphur with vaseline with the addition of 3 per cent. of resorcin. The latter seems to facilitate the removal of the scales, but I am not sure that its addition is essential. The application of this salve to the edge of the lid at night shows an influence which may be almost termed specific, only, however, in the squamous, not in the ulcerative form of the disease. Lids which have been red and unsightly for months and years often assume a normal appearance within one week. While it may be well to use the salve for some four to six weeks to guard against relapses, I have found that if its full benefit is not obtained in two or three weeks, it is due to some of the predisposing influences which then require attention. Of course, we should not attempt to cure a blepharitis without previously restoring the permeability of diseased lachrymal passages except on the patient's distinct refusal to submit to any operation. Where lachrymation persists it is scarcely possible to remove the blepharitis. In the case of hypermetropia or astigmatism the necessity for correction by glasses exists only if the eye-strain is either noticeable to the patient in any way, or if a few weeks of local treatment has not succeeded in curing the blepharitis. Finally, as to nasal influence, our therapeutic measures must also be guided by the circumstances. If the patient does not wish any nasal treatment, we may as well attempt to cure the blepharitis by local means, which will generally be successful. If this cannot be accomplished, there still is time to treat whatever disease of the nasal cavity may be found.

<sup>1</sup> Die Entzündungen des Lidrands: Wiener klin. Wochenschrift, 1888, Nos. 38 and 39.

## CLINICAL MEMORANDA.

## MEDICAL.

*Two Cases of Tetanus in Infants, with Remarks.*—The two cases here detailed are both instances of tetanus in the newborn infant, but the first was evidently due to an injury to the head, and, therefore, can scarcely be classed as a case of infantile lockjaw, notwithstanding that the state of tetanic convulsion was present. The second is a typical case of trismus nascentium, about which so much has been written.

CASE I.—I was called about noon of October 16, 1889, to see Lizzie M., single, white. The history given me was that, save some restlessness at night, she had been perfectly well until 1 A. M., of the morning I saw her, when she suddenly became totally blind. In the course of my examination, I found she was pregnant. A small quantity of urine was obtained, which was afterward found to contain casts and albumin. After I left the house to examine the urine, the woman had a terrible attack of convulsions, for which I gave her hypodermics of pilocarpine and nitro-glycerin and large doses of bromide and chloral. She soon had a second and last convulsion. Labor commenced almost immediately, and was terminated successfully by a high forceps operation under chloroform. The bones of the child's head were unusually movable, and I was able to depress the occiput to a great degree during my examination. The child was asphyxiated, but speedily revived and cried feebly. Its head was marked slightly over the right parietal protuberance and the temporal region on the same side. Two hours after birth it had a convulsion. I found it in the morning in the following condition: The left side of the face paralyzed; the right side of face the seat of tonic contraction, being much puckered and the jaw tightly shut. The right eye firmly closed, the left open. The left arm and leg were not paralyzed; both arms were drawn tightly to the side, the forearms flexed on the arms, and the fingers tightly flexed with the thumbs across the palms. The body of the child could be moved as if composed of a single piece, if lifted by the strongly flexed arms. The legs were rigid, the knees being slightly bent. Any disturbance of the child would bring on frightful paroxysms, in which it would almost succumb. It expired forty-eight hours after birth.

No post-mortem was allowed.

From the fact that severe compression and traction were made during delivery, and the additional fact that the left side of the face was paralyzed, it is safe to attribute the tetanic convulsions from which the child died to the use of the forceps. Though the convulsions were tetanic and not clonic, the case will scarcely come under the head of trismus nascentium, as it lacked many of the characteristics of that disease and had the potent cause of injury to the head by the forceps.

CASE II.—Mrs. G., colored, was taken in labor 6 A. M. on October 25, 1889. The os was but slightly dilated when first seen about noon, and I left with instructions to send for me when needed. About 6 P. M. I was hastily called and found the child, an unusually well-formed and large male, born. All went well until the morning of the ninth day, when the mother said that the child had

worried all night and seemed unable to nurse. On examination I found all of the muscles of the face strongly contracted, the jaws firmly locked, the arms tightly drawn to the side with thumbs in the palms. It could swallow with but little difficulty, but was evidently in great pain. The umbilicus had not healed, a large ulcer covered with pus occupying the seat of the separated cord. The next morning the jaws were still firmly locked, and the least disturbance would bring on frightful tetanic convulsions. The child's face was constantly wrinkled by the contracted muscles. The head was retracted, the elbows bent, the thumbs in palms, the knees drawn slightly apart, legs bent at knees, the great toes adducted, and the other toes flexed. The child could be lifted without bending the spine, by placing a hand beneath the heels and occiput. The pupils were contracted. There was no strabismus. The child lived in this condition for twenty-four hours; the least disturbance causing the frightful paroxysms, but continuously in a state of tetanic convulsion. Temperature 105.5°.

Post-mortem, fifteen hours after death: The rigor mortis, which was marked two hours after death, had partially disappeared. Examination of the brain was not permitted. The condition of the bones of the head which existed during life persisted. The sagittal suture was widely open. The occipital bone was markedly depressed, being overlaid by the edges of the parietal. The umbilical ulcer was covered with a thin, dry crust. The lungs were highly congested, and the heart was distended with blood; otherwise the thoracic and abdominal organs were in a normal condition. The umbilical vein was patulous and was not the seat of any inflammation. The left hypogastric artery was filled with a clot, the right was free. I removed the bodies of the fifth and sixth thoracic vertebræ. The posterior part of the canal was the seat of extravasated clotted blood. There were no clots within the dura mater, though the veins were slightly congested.

There can be no doubt that this case is a case of trismus nascentium, with the irritated umbilicus as the probable cause. Various and diverse theories have been advanced to explain this most curious and fatal disease.

In 1846, Dr. Marion Sims published a paper in the *American Journal of the Medical Sciences* in which he attributed the malady to a depression of the occipital bone, and claimed that the disease could usually be cured in its incipency by simply turning the child on its side. He held that laying the child on its back, with its occiput resting on some hard substance, increased the depression of the occiput which always exists after birth. This theory was upheld by Dr. Hartigan, as late as 1884.

Dr. Watson, of Charleston, answered this article of Sims in 1851, and gave as the cause, inflammation in or around the umbilicus. In answer to the criticism that the umbilicus is frequently healthy in cases of trismus, he cites the fact that the wound which is the cause of traumatic tetanus is frequently found in a healthy condition at the onset of the disease.

Beside these two causes there is scarcely an accident to which an infant is liable that has not been cited as the causation of trismus. All authors agree that the disease is most frequent among the poor with bad hygienic surroundings, and that it may also occur in epidemics.

The latest theory I have seen is that advanced by A. D'Erpine and C. Picot, of Paris, in a volume on diseases

<sup>1</sup> Reported to Philadelphia Pathological Society.



of children published this year. They consider trismus nascentium, in common with ordinary traumatic tetanus, an infectious disease due to a specific microbe.

The treatment is highly unsatisfactory. Most drugs have been used without effect, the antispasmodics, notably chloral, being used most frequently at the present day. Sims's treatment by position alone is not mentioned by the later authors. Soothing and antiseptic dressings to the umbilicus, when it is irritated, seem of value. Prophylactic measures, viz., improvement in the hygienic surroundings, cleanliness of the infants, care in dressing the cord, seem to have been the important measures in breaking up the various epidemics.

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189 GREEN LANE, MANAYUNK

**A Contribution to the Physiological Study of Infantile Digestion; a Preliminary Note.**—For several months I have been engaged in the examination of the contents of the stomach, and also of the excreta, in nursing and artificially fed infants, and I desire to record in this preliminary note certain conclusions reached from these investigations.

The method has consisted in the chemical estimation of the amount of albumin, sugar, water, solids, fat, and ash in the stools of healthy and dyspeptic infants, and the examination of the contents of the stomach at varying intervals after feeding, by the chemical tests recently introduced for the study of gastric disease. These reagents have been Uffelmann's iron and carbolic acid test for lactic acid; Congo paper; the yellow tropæolin, and methyl-violet. Finally, the milk clot from the stomach has been microscopically examined to ascertain the degree of disintegration of the fat globules of the ingested milk, and to determine the presence of bacteria.

From these investigations the conclusions are reached that the stomach of the nursing infant and of the infant fed on sterilized milk, when both are healthy, contains neither hydrochloric nor lactic acid; when gastric catarrh is present or when high temperature has recently existed an acid, or acids, is found which reddens litmus, but does not respond to tests for hydrochloric and lactic acids. The milk clot from healthy infants, whether breast- or sterilized milk-fed, contains no bacteria, and its fat globules are reduced to granular matter in from half an hour to one hour after feeding. In proportion as gastro-intestinal catarrh exists the excreta of nursing and artificially fed infants contain an excess of undigested fat.

These results of investigation, combined with the clinical study of infantile digestion and its disorders, warrant the inference that in the digestion of the infant hydrochloric and lactic acids do not normally exist; that milk is clotted by a rennet ferment active in alkaline or neutral media; that the stomach serves the purpose of a coagulating bottle which is empty in less than an hour after feeding; that digestion and absorption proceed according to the activity of the pancreatic and intestinal secretions, the pancreas being especially concerned in normal digestion and the lack of its functional activity being most apparent in gastro-intestinal disease. It is my purpose soon to discuss further and elucidate these points.

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## ANATOMICAL.

**A Diverticulum from the Ileum.**—In recording the following case I desire chiefly to call attention to the curious and interesting blind pouch which was discovered attached to the ileum, but also to note a peculiar inflammation of the sigmoid flexure of the colon. Further, I trust that this imperfect clinical record may aid in the appreciation of the peculiar difficulties in diagnosis constantly encountered by medical officers in hospitals for the insane:

Barbara R., a German, aged sixty-four years, married; transferred to this hospital from the Insane Department of the Philadelphia Hospital, where she had been for eleven years, after the fire which destroyed nearly all the buildings of that department in 1885.

Her mental condition during the four years of her residence here was that of chronic mania with delusions, and I have no doubt she was in the same condition while at the Philadelphia Hospital. Like many cases of this kind, she did much useful work, going out to the laundry and ironing-room regularly during the greater part of the time she was here. She was almost constantly either muttering to herself or talking aloud to persons whose voices she imagined she heard. She also had hallucinations of sight, and, in consequence, many delusions, and gave irrelevant answers to questions, or no answer at all.

About the middle of last August she began to lose much of her energy for work, but continued scolding and muttering to herself, as was her custom.

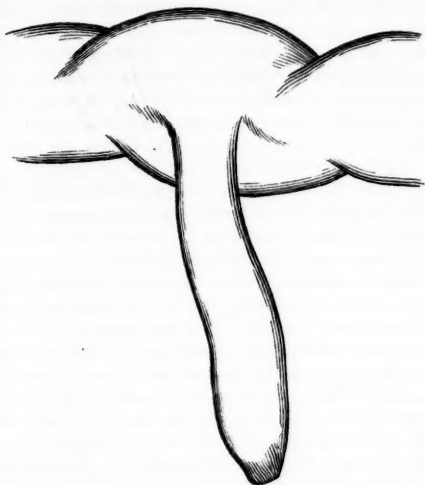
October 20th she vomited several times, and had some diarrhoea, the stools being light in color; she was put to bed, and the next day there was vomiting, but no diarrhoea. The general asthenic condition of the patient appeared to be out of all proportion to the objective symptoms, which did not seem to be grave. Strangulated hernia was suspected, but careful examination failed to discover its presence. She had cold sweats and subnormal temperature, and died October 24th.

**Autopsy,** eighteen hours after death: Body much emaciated; rigor mortis not marked. Heart firmly contracted; posterior leaflet of mitral valve strongly adherent in the half of its area nearest the line of insertion, so that the free surface of the valve was only about one-half of its normal area. Lungs normal. Small intestine normal in calibre, except in three or four places, where the lumen was contracted from one-half to three-quarters. The smallest length of intestine with diminished calibre was about four inches, the longest a foot.

Proceeding from the ileum, about two feet above the ileo-cæcal valve, an appendage or diverticulum was discovered. It was about four inches in length, and with a lumen of sufficient size to permit the introduction of the middle finger. It joined the intestine nearly at right angles, and was of a uniform diameter in its entire length, though a trifle smaller nearer the extremity than at the junction with the bowel, as seen in the cut. A slight uniform dilatation of the ileum was noted in the region of the bowel from where proceeded this process. The diverticulum, or "blind gut," ended in a rounded, slightly sacculated extremity, and was filled with soft fecal matter.

The large intestine varied greatly in its lumen; in the

ascending and part of the transverse colon being very large, then a sudden diminution in the diameter, until it would not permit the introduction of an object larger than the thumb. This contracted portion of the bowel was about ten inches long. It terminated suddenly in



an expansion, which, in its maximum lumen, was about twice as great as that of the normal bowel. Lower down in the colon—about the sigmoid flexure—for the extent of nearly a foot, the bowel presented a livid, maroon color, and at some points was almost black. A thick, tenacious material was strongly adherent to the interior aspect of the inflamed portion of the gut. No signs of inflammation in other parts of the bowels were noticed.

REMARKS.—This peculiar inflammation, amounting almost to gangrene, in the lower part of the colon, possibly was caused by an embolus or thrombus, which cut off the nutrition of this part of the bowel—at all events, this local trouble was probably the immediate cause of death, although in a patient of this kind grave organic disease might have coexisted and have escaped notice—even at the post-mortem.

That anything more than an approximate diagnosis was possible I cannot believe. Indeed, such conditions in a rational person would certainly have been difficult, and perhaps impossible, to diagnose. As to the diverticulum, it might have been congenital or acquired. The fact that the bowel was so enormously contracted and dilated (a condition I have a number of times noted in autopsies upon the insane, and which I believe to be due to the habit of constipation) is favorable to the latter view. On the other hand, the peculiar form and size of the diverticulum would seem to indicate that the anomaly was congenital.

For the accompanying drawing I am indebted to the kindness of Dr. G. R. Trowbridge, of this hospital.

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#### THERAPEUTICAL.

##### *Compressed Pills of Salol and Terpene Hydrate in "Colds."*

—For two years past I have been using, in my service at the Philadelphia Polyclinic and in private practice, in

the treatment of "coughs and colds"—that is to say, mild attacks of bronchitis and of catarrhal fever, acute and subacute, a pill consisting of

Salol	}	of each 3 grains;
Terpene hydrate		

made and compressed for me by Mr. Kyner, the apothecary of the Polyclinic. These pills are now kept in stock for dispensing, or for sale to apothecaries by Messrs. Kyner & Kyner, and by Mr. Frank E. Morgan. The dose is one or two pills every second, third, or fourth hour, according to indications.

The results of this plan of treatment are quite satisfactory, especially in those cases of "general cold" or mild catarrhal fever, in which there exists more or less muscular and articular pain, associated with symptoms of bronchial catarrh; cases which I formerly treated with cinchonidine salicylate. In the more severe type of "colds," approaching more closely the typical influenza, of which we always see a number of cases in this city at this season of the year, as well as in the early Fall and in the early Spring—it is well to combine with the treatment mentioned, the use of some good alcoholic preparation of bark, or even quinine and whiskey. Fluid extract of coca is also quite useful. When the nasal symptoms are troublesome, they may be completely relieved by the judicious use of belladonna or atropine. The dose will vary with different individuals. It should be just short of the quantity required to produce full physiological effect. In cases where severe lumbar pains suggest renal congestion, the prompt administration of some simple alkaline diuretic, such as solution of ammonium acetate, with spirits of nitrous ether, is of benefit.

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#### MEDICAL PROGRESS.

*The Preparation of Lister's Double Cyanide Gauze.*—SIR JOSEPH LISTER, in the *Lancet* of January 4, 1890, describes the method of preparing his new surgical dressing thus: Cyanide of potassium, cyanide of mercury, and sulphate of zinc are mixed together in solution in quantities proportioned to their atomic weights; the cyanide of potassium and cyanide of mercury being dissolved together in  $1\frac{1}{2}$  ounces of water for every 100 grains of potassium cyanide, and added to the sulphate of zinc dissolved in three times that amount of water. The precipitate is collected on a strainer, and when well drained is washed with two successive portions of water, equal in quantity to that used for the solution—viz.: 6 ounces for every 100 grains of potassium cyanide; at least this amount of washing being essential in order to free the precipitate sufficiently from the highly irritating soluble salts which are associated with it in its formation. The precipitate having been thus washed and drained, but not dried, it is thoroughly diffused with pestle and mortar in distilled water (6 ounces for every 100 grains of potassium cyanide), containing in solution 1 part of hæmatoxylin for every 100 parts of the cyanide salt, the amount of which is known from the circumstance that the dry product of cyanide salt is almost exactly equal in weight to the potassium cyanide employed. Hæmatoxylin is readily

soluble in a small quantity of hot water, and remains in solution when added to a large quantity of cold water. The cyanide salt, while it precipitates the hæmatoxylin, changes its color to a pale-bluish tint. This is advantageously enhanced by the addition of a little ammonia to the mixture in the proportion of 1 atom of ammonia to each atom of hæmatoxylin. More than this proves prejudicial. The ammonia is added in a dilute form, and it is convenient to have the dilution such that one fluid drachm of the ammoniacal liquid shall correspond to one grain of hæmatoxylin. The dye is further economized by allowing the ammoniated mixture to stand for three or four hours, and stirring it occasionally, so that the ingredients may react thoroughly upon each other. If the mixture is filtered immediately, there is considerable loss of coloring matter. The dyed salt having been drained and dried at a moderate heat, is levigated, and may then be kept for any length of time. When employed for charging a dressing, it is diffused by means of pestle and mortar in solution of bichloride of mercury (1 to 4000) in sufficient abundance to drench the fabric thoroughly, for which 4 imperial pints to 100 grains of the salt will be found adequate. This will give a percentage of between 2 and 3 of the cyanide to the dry gauze. The gauze should always be used moist; and if it be prepared for immediate use, the process of drying may be omitted, the gauze, after being hung up for a while to drain, being further deprived of superfluous moisture by placing it in a folded sheet. It may afterward be conveniently kept moist by wrapping it in a piece of mackintosh cloth. When obtained dry from the manufacturer, it should be moistened again with the weak corrosive sublimate before it is used.

**The Diagnosis of Syphilis and Malignant Disease.**—DR. EDUARDO CONTE (*Il Progresso Medico*, December 1, 1889) gives some striking illustrations of the difficulties which often surround the diagnosis of syphilitic formations from cancerous and other malignant neoplasms. Though the subject is well worn, it is one of perennial interest to surgeons, as every one who has ever followed the practice of a hospital even for a few months must have seen cases in which swelling or ulceration due to syphilis has been mistaken for cancer, with the result, possibly, that some organ (generally the tongue) has been removed or mutilated without necessity. The opposite mistake is, perhaps, still more common, and under the plea of "giving the patient a chance," malignant disease is allowed to run on whilst precious time is lost in futile antivenereal medication. Under these circumstances, as Mr. Butlin well puts it, the "chance" is given, not to the patient, but to the disease. Dr. Conte's first case was one of syphilitic disease of the lower lip in a married lady, aged thirty-four, with two healthy children. She noticed a pimple on her lip, which, after some time, broke, the ulcer discharging a thin purulent secretion and showing a marked tendency to spread. It was repeatedly cauterized without effect, and the submaxillary glands became much enlarged. In the absence of any history or evidence of syphilis, the case was diagnosed as one of epithelioma, and the patient was urged to have the tumor excised. Dr. Conte, however, considering that the tumor was softer in the middle than elsewhere, and taking into account the brownish-red color of the ulcer, the thin purulent discharge, the absence of hæmorrhage, together with the

painlessness of the swollen glands, came to the conclusion that it was syphilitic, and treated it with iodoform, which effected a cure. Subsequently condylomata appeared about the anus and vulva, with a syphilitic rash upon the body and enlarged glands in the neck and groin. The infection was traced to smoking cigarettes which a young man with mucous patches used to light for the patient. In another case an officer of the Italian navy, aged forty-five, had an ulcer on the scrotum which was diagnosed as malignant. The ulcer was circular in form, measured one centimetre in diameter, and had raised edges. There was a thin discharge, and the surrounding tissues were thickened; not far from the ulcer there was another about half as large. The inguinal glands were enlarged. No history of venereal disease beyond gonorrhœa in early youth could be obtained. Dr. Conte, nevertheless, diagnosed the case as one of subcutaneous gummatous nodules. Iodide of sodium was given internally: cotton-wool soaked in a 1:1000 solution of corrosive sublimate was applied to the ulcers, and the same preparation was injected hypodermically to the amount of 1 centigramme a day, the patient, who would not listen to any hint that the disease was syphilitic, being led to suppose that it was morphine that was injected for the relief of nocturnal headache, of which he complained. Complete cure followed this treatment. Several other cases illustrating the difficulties in the differential diagnosis of these affections are also reported by the author. —*London Medical Recorder*, December 20, 1889.

**Flushing the Peritoneum after Abdominal Section.**—With a novel object in view, MR. JOHN D. MALCOLM (*Lancet*, January 11, 1890) insists upon the importance of washing out and distending the peritoneum with water after laparotomy. If, as he says, in finishing the process of washing out the peritoneum, the abdominal cavity be distended with fluid, the intestines must be floated up toward the highest level of the cavity. As the intestines are thus buoyed up by the fluid, it is obvious that changes in the relative positions of the various coils must be greatly facilitated, while the traction which is at the same time brought to bear on the mesentery, must tend to straighten out that membrane in its attachments to the posterior abdominal wall and to the bowel, and so to undo any acute twists which may exist. The mesentery and bowel will thus be thrown into natural folds. If the fluid be then simply permitted to flow out of the abdominal cavity, or be carefully sucked out of the pelvis by means of a tube, without sponging or other mechanical disturbance, the intestines will tend to settle down in a natural position, just as they do when an ascites is relieved by tapping. In no other way can so satisfactory an adjustment be assured. It seems, therefore, that one of the most important, if not the most important, of the advantages to be secured by the free use of fluid in cleansing the peritoneal cavity, is the facility which this method of procedure affords for securing a natural disposition of the coils of the gut. A normal position being thus obtained, adhesions may form without giving rise to serious consequences.

Of interest in connection with the consideration of the normal arrangement of the intestines of these cases, is the assertion that patients who suffer much from chloroform vomiting after an abdominal section, not infrequently recover more satisfactorily and more quickly than those



who are not so affected. Dr. Malcolm suggests as an explanation, that if a patient be constantly straining and retching for five or six hours or more after an operation, however much the intestines may have been displaced, the shaking of the abdomen must tend to bring them into a natural position again before adhesions can take place or become firm. If, on the other hand, there be little or no vomiting, and if the patient lie quiet, adhesions may form so as to fix the more or less paralyzed intestines in the position in which they have been placed, and so left, by the hand of the surgeon, which may not be a natural one.

**The Doses of Digitalis and Strychnine.**—In the *Therapeutic Gazette*, January, 1890, Dr. HENRY M. FIELD expresses very decided views upon the doses of digitalis and strychnine usually employed. Long experience has convinced him that for cardiac conditions demanding digitalis, whether neurotic or structural, five drops of the tincture three times daily is usually a sufficiently large quantity. Press the remedy further, and evidence will be presented of a tetanized heart, although perhaps in slight degree. Here it is to be remarked that the chief experience of this writer has been in cases of weak and irritable hearts, caused, it may be, by various excesses, and most often encountered in adults who have long been overburdened by business responsibilities. Few other results in practical therapeutics are so sure to be satisfactory as are those which follow the use of digitalis in such conditions; but success depends upon reform, so far as possible, in the fault which produced the cardiac difficulty, and upon systematic regular ingestion of the tincture in doses of not more than five drops three times daily for months.

The alkaloid strychnine he considers should never be prescribed, for the reason that it is extremely insoluble, and when the drug is required it should be administered as a soluble salt, such as the sulphate. When the sulphate of strychnine is prescribed as an adjuvant to a laxative, the dose should be not less than one-fortieth of a grain. A pill composed as follows is used by Dr. Field as an aperient:

R.—Aloin . . . . .	$\frac{1}{3}$ grain.
Sulphate of strychnine . . . . .	$\frac{1}{10}$ "
Extract of belladonna . . . . .	$\frac{1}{10}$ "
Powdered ipecacuanha . . . . .	$\frac{1}{2}$ " —M.

One such pill will usually be found sufficient.

**The Hypodermic Syringe in Diagnosis.**—Aspiration by means of the hypodermic syringe has come to be so much employed of late years, that a simple suggestion of a means by which the result may be rendered more reliable seems worth noting. One of the strongest objections to the ordinary use of a hypodermic needle for diagnostic purposes is that a positive result can alone be regarded as of certain value. The fact of not obtaining pus or other fluid, even when several punctures have been made, affords no reliable evidence as to the non-existence of a fluid-containing cavity. In the majority of cases pus will readily flow through a needle, but the lack of reasonable certainty in the event of a negative result is highly unsatisfactory. A suggestion offered by Dr. F. T. KING is as follows: Draw boiled water into the syringe until it is about one-third full, and, after punctur-

ing, slowly expel a few minims into the supposed cavity, then gently withdraw the piston, and if a collection of fluid exist, we are practically sure to obtain a specimen of it for naked eye or microscopic identification. He first tried this plan in a case where only a negative result could be obtained by the ordinary method, though the pus flowed freely when it was diluted. Since then he has used it in a large number of cases with the view of testing its value, and has never failed to satisfy himself with a single puncture. There is rarely any necessity to expel more than about three minims of water, but, if this fails, the piston may be driven further home, or even worked in and out several times.

Dr. King thus summarizes the advantages of his method: 1. The needle is cleared. 2. The tension of the fluid is increased. 3. The fluid is rendered thinner.

When a syringe is used in this manner, great care is necessary in thoroughly cleaning and disinfecting the barrel after each injection.—*British Medical Journal*, January 11, 1890.

**Codeine in Ovarian Pain.**—Dr. FREUND, of Strassburg, has recently used codeine in a large number of cases of abdominal pain from various causes, with the view of testing the assertions of Dr. Brunton that the drug is of especial use in intestinal or pelvic pain. His results seem to indicate that Brunton's views are somewhat exaggerated.

Pain from acute uterine affections, such as dysmenorrhœa, Freund found, was not as quickly relieved with codeine as with morphine, and the relief was of shorter duration. In pain from pelvic exudates and tubal disease the drug was also of but little value. In ovarian pain, however, whether from prolapse, oöphoritis, perioöphoritis, or neuralgia, the relief afforded by codeine was prompt, unmistakable, and more or less permanent even when small doses were given. The amount usually administered was about half a grain three times daily in pill form, and in but few cases was it necessary to increase this quantity. His experience coincides with Brunton's that no disagreeable or harmful effects follow the use of the drug. It does not stupefy, diminish the appetite, nor constipate. He prescribes the pill for one month after an attack of ovarian pain, and warmly recommends the drug for the above conditions.—*Therapeutische Monatshefte*, November, 1889.

**Three Diagnostic Signs of Melancholia.**—In the simple form of melancholia, as is well known, there is melancholy, which is usually unattended by delusions, hallucinations, or illusions, although there may occasionally be delusional or hallucinatory tendencies, but there is none of the agitation or stupor of the other forms. The simple forms of melancholia are often extremely difficult to diagnose, especially in the early stage, as the reasoning powers, the memory, and the perceptions are then often seemingly unimpaired, or not more affected than is possible from many unimportant causes. Patients suffering from this mental disease frequently figure as neurasthenics, and are confidently treated as such until some determined and frightful suicidal or homicidal attempt throws startling light upon the true nature of the malady. These, too, are the cases of mysterious suicides which are accounted for on some theory of

rejected love or high-flown sentimentalism. Any certain diagnostic symptoms in this class of cases should be for these reasons of value. In sixteen cases of melancholia which have come under the observation of DR. LONDON CARTER GRAY in the last eighteen months, he has found three constant symptoms, viz., melancholy, marked insomnia, and a post-cervical ache. The post-cervical ache is an aching pain in the back of the neck and head, and sometimes extending to the shoulders. It is usually described as a distress or ache, although it may occasionally be neuralgic in its character, and not infrequently passes into neuralgic paroxysms which will last for a day or two.

The insomnia is usually one of the earliest symptoms of the disease, but has no especial characteristics.—*Journal of Nervous and Mental Diseases*, January, 1890.

**The Surgical Treatment of Tubercular Peritonitis.**—In the *Centralblatt für Chirurgie*, No. 40, 1889, SPAETH holds that the statistical results of the operative treatment of peritoneal tuberculosis must be received with considerable reserve, owing to the absence of identification of tubercle bacilli. Of four cases in Prochowick's clinic, in which the tubercular nature was thus proved, one died early from collapse, and the other three within a few months from general tuberculosis. Although he does not on this account deny the possibility of cure, Spaeth believes that the statistical results are doubtful. He submits the following propositions:

1. In primary abdominal tuberculosis, without implication of other organs, laparotomy is satisfactory.
2. In peritoneal tuberculosis, with involvement of the female generative organs, the operation has as yet given no definite results, whether these organs have or have not been removed.
3. If the intestines be involved the operation is only palliative.
4. In genital tuberculosis, without peritoneal invasion, operation should be performed as early as possible, but an early bacterial diagnosis is difficult to obtain.
5. Primary peritoneal tuberculosis is much rarer than is generally supposed, hence the diagnosis should be made with care, and only accepted if confirmed by bacteriological observation.—*Medical Chronicle*, January, 1890.

**The Extirpation of Benign Tumors of the Thyroid.**—The excellent results obtained by MR. CHARTERS SYMONDS in his treatment of these growths by extirpation, as detailed by him at a recent meeting of the Clinical Society of London, will serve to draw the attention of other surgeons to the method of treatment therein recommended. Mr. Symonds laid stress upon the following points: The median incision is to be made in all cases and the capsule of the cyst to be looked for—as a rule, it is at once seen if the tumor be superficial, or a part of it projects beyond the margin of the gland; when the cyst is found to contain fluid, all is to be evacuated and the cyst peeled out, or, if the tumor be solid, it is to be enucleated. In some cases the margin of the gland must be raised up. In two of Mr. Symonds's cases the lobe was removed on the supposition that the growth was incapsuled intimately; but afterward this was not found to be the case. All his eight cases did well, primary union resulting in every one of them; and there was no hæmorrhage in the

simple cases. The rapid recovery of his patients generally contrasts favorably with the much slower progress of patients treated by other methods. Thus, tapping and injecting with perchloride of iron is apt to produce hectic, and some patients thus treated have almost lost their lives. In fact, when much solid material exists in the growth injection is unsuitable. If such cases be treated by injection, serious results are likely to occur. If the cyst be opened and sutured to the skin, and stuffed, the case is long under treatment, the resultant scar is large, and there is more danger than when excision is performed. Possibly a small incision and scooping out of the tissue may in some cases succeed; but it appears to be attended with much danger of hæmorrhage. In one of Mr. Symonds's cases which was exhibited, the cicatrix was only an inch and a quarter long, although an adenocystoma, measuring three by two inches, had been removed. In this case the fluid had been first evacuated, after the manner recommended.—*British Med. Journal*, January 11, 1890.

**The Treatment of Chronic Prostatitis.**—PROFESSOR HENRICH KÖBNER, of Berlin, has for some time used, with good results, the iodide and bromide of potassium, administered by the rectum, in the treatment of chronic prostatitis. At first the salts were administered with cocoa butter in the form of suppositories. These, however, frequently caused irritation and burning of the rectum, which was due to the fact that the suppositories were slow in melting. For this reason he now uses the drugs in solution as enemata. The formula which he recommends is as follows:

R.—Potassium iodide	. . .	4 grains.
Potassium bromide	. . .	3 to 4 "
Extract of belladonna	. . .	1/3 grain.
Water	. . .	5 drachms.

This amount is to be added to from 1 1/2 to 3 ounces of warm water and injected once, later twice, daily. Further in the course of treatment the iodide and bromide may be increased to three times the above amounts.—*Therapeutische Monatshefte*, November, 1889.

**Sulphur in the Treatment of Diphtheria.**—Sublimed sulphur is strongly recommended as a local application in diphtheria, by DR. CHARLES SMITH, of Australia (*Australian Medical Journal*, December 15, 1889). The throat is first mopped with a solution of tannin in glycerin; simply painting with a brush is not sufficient, as the object is to remove the membrane as far as possible, and to leave a sticky surface. A small quantity of sulphur is then insufflated upon the diseased surface, and as it should remain there for at least fifteen minutes, the patient is neither allowed to expectorate or swallow for that length of time. The author considers it essential to repeat this at least every hour, day and night. The small amount of sulphur swallowed occasionally relaxes the bowels, but not to a great extent, unless larger amounts than necessary are used. According to Dr. Smith, with this treatment the diphtheritic process usually quickly ceases to spread and begins to improve within forty-eight hours, though appreciable change is not always so rapid. How this method of treatment is applied in cases of laryngeal diphtheria does not appear from the paper in question.

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## THE TREATMENT OF SYMPTOMATIC HÆMORRHAGE.

PROBABLY no symptom is more alarming to the friends or, as a rule, a source of greater anxiety to the medical attendant than hæmorrhage. Its immediate checking naturally seems to the bystanders the first duty of the physician, yet in many cases it would be far better for the patient to lose some blood and so have the benefit of nature's method of relieving, by this safety-valve leakage, the diseased condition of some organ, than that the hæmorrhage should be controlled by medicinal or other treatment. Urged by the patient's friends, and feeling the "necessity of doing something," the physician mayhap often controls the hæmorrhage to the detriment of some diseased organ whose relief could be secured in no other way so speedily or completely as by the drain of blood from the overfilled vessels.

In hepatic disease attended by portal obstruction the rectal hæmorrhages, often too actively treated, may relieve symptoms which otherwise might be overcome with difficulty or not at all. By epistaxis nature often takes it upon herself to relieve intracranial congestion and, if read aright, will offer material assistance as an indication of the proper mode of treatment to be adopted. Many other examples of this safety-valve leakage from over-distended vessels might be adduced. In all cases to treat

hæmorrhage as hæmorrhage, and not as a possible symptom of disease of deeper origin, is as irrational as to treat all headaches with nerve sedatives. In the *Gazette Hebdomadaire de Médecine et de Chirurgie* for November 8, 1889, is an excellent article by Guinard upon the treatment of hæmorrhage from other than large vessels. He relates several cases of epistaxis cured by the application of a vesicatory over the hepatic region. In some of the cases so treated the diagnosis of hepatic disease had already been made; in these the hæmorrhage was arrested by the measure employed; in others the cessation of hæmorrhage after the application to the area named led to the detection of previously unrecognized hepatic disease; in a third class the application failed to control the hæmorrhage, and in these no hepatic lesion was present. He also relates cases of hæmorrhage due to malarial infection and to disease of the kidneys, which ceased under treatment applied to the underlying cause.

Epistaxis is so frequent an occurrence in apparently perfectly healthy individuals, and of itself is so seldom of serious consequence that we may, unless we are constantly on our guard, pay attention to the surface play without considering its significance as the outward and visible sign of some causative visceral disease. As with coryza, so with epistaxis the symptom may be heroically attacked, leaving the underlying renal disease to pursue its course unnoticed.

The rational method of treatment is to remove the cause of symptoms produced, and only after careful investigation of other organs, that could be capable of producing the symptom, should the hæmorrhage be considered as idiopathic and due to some local condition.

Were we to picture fully to ourselves the physical condition of the diseased organs that we have to deal with, and, so to speak, to put ourselves in their place, we might often change materially our plan of attacking the symptoms presented.

Too often does the physician, urged (perhaps against his will) to stop the hæmorrhage, turn with confidence to ergot as the great hæmostatic, and in giving the remedy feel that he is "doing something" to the quieting of his own conscience and of the clamor of the patient's family. No matter from what source the hæmorrhage may come, or to what cause it may be due, ergot is looked upon by many as the panacea for hæmorrhage. From the fact that uterine hæmorrhage is controlled by ergot,



the conclusion is drawn that all hæmorrhage can be surely and safely checked by the same means; yet probably the action of ergot as a stimulant to the contractile power of the uterine tissue has more to do with its ability to stop post-partum or other hæmorrhage from the same organ, than has any hæmostatic property possessed by the drug.

That ergot is a powerful vaso-motor stimulant makes it of vast value in the treatment of such hæmorrhage as arises from disease of the vaso-motor system in which subcutaneous, submucous, or external hæmorrhages occur. Here its action is intended to affect the whole bloodvessel system of the body, and its use is rational. It is far different when we have to deal with hæmorrhage due to the rupture of a vessel from local disease of its walls or of the surrounding tissue. By giving ergot in the latter condition we increase blood-pressure enormously by contracting *all* of the arterioles of the body, we increase the strain upon the diseased and weakened vessel-wall as well as upon those of the healthy vessels, and we must of necessity not only render further rupture possible, but also increase the outflow from the bleeding vessel, thereby perhaps destroying the chance of clot-formation, by which alone the leak can be repaired. It is impossible to see how ergot could have any selective action upon the ruptured vessel, picking it out from the rest and diminishing its calibre, and it is but natural to believe that a vessel so diseased as to suffer rupture of its wall, cannot contract so well as do the healthy vessels throughout the rest of the body.

If the above view is correct, it is improper to administer ergot for the checking of hæmoptysis, and unwarrantable to attempt to prevent a recurrence by repeated doses of the drug after the first leak has been plugged by a clot. In cerebral apoplexy the same remarks would apply with even more force, as we have here to consider the fact that the more fully the cerebral vessels are dilated, the less room is there for the accommodation of the outpoured blood, and that by contracting the unruptured bloodvessels we not only increase the force of the blood stream through the already ruptured vessel, but also make room for more blood to be poured out, and invite its exit through the rent. It is not the blood *in* the cerebral vessels that causes the damage, it is the blood *outside* of them.

Were a leak to occur in a branch of the conduits leading from a reservoir of water, the method adopted to check the outflow would surely not be to

narrow or occlude all other branches, or to remove all external opposition to the free discharge from such a leak; yet with local disease of one part of the vascular system the analogy will hold, as the atheromatous and friable cerebral vessels, and the thickened infiltrated vessels in the walls of a pulmonary cavity certainly cannot be capable of much contraction under the influence of ergot or any general vaso-constrictor.

Far better is it to quiet the strength of the blood current, to divert the stream so far as possible into healthy channels widened for the reception of as much blood as is possible, to quiet the heart's action and so allow nature unopposed to attempt to plug the leak by clot-formation.

With some modification the same method of reasoning applies to the use of ergot in the hæmoptysis of mitral disease, where by the administration of the drug all of the arterioles are contracted, and thereby more obstruction opposed to the blood flow from the already incompetent heart. Here the method of attacking the cause would be by aiding the heart to keep up the lesser circulation, while at the same time endeavoring to lessen, instead of increase, the *vis-a-fronte* in the greater circulation. A severe, but not fatal, hæmorrhage, if unchecked by medicinal measures, continues until syncope occurs with practical absence of blood-pressure. If the syncope or rather the low blood-pressure, last sufficiently long, clot-formation occurs at the bleeding point and the hæmorrhage ceases. If the patient be raised from the recumbent posture, hæmorrhage may recur from the rise of blood-pressure produced by the change of position sweeping out the clot that may have formed. The pointings of nature are always wise and safe, and the more we assist instead of opposing her and the more we attempt to imitate her methods, the more rational will be our treatment and the more certain our results.

#### THE UNITED STATES PHARMACOPŒIA OF 1890.

THE fact that the United States Pharmacopœia of 1890 is about to be acted upon by the decennial convention next spring, should excite very considerable attention among the members of the medical profession everywhere. It is of the gravest importance that the physicians of the United States should send as representatives to Washington a band of men who will be representative of all that is practical and nothing that is commercial. At the last

revision, the commercial element was so strong that science had little or no standing, simply because the physicians who should have been there failed to appear, either through lack of interest, fear of expense, or because the various medical bodies of the country had not sent delegates properly accredited. There is no doubt, however, that the physician should have a large amount to do with such a task, for it is his practical application of remedies that forces the pharmacist to keep on his shelves the drugs required. He alone can separate, by reason of his experience, the useless drugs from the good, and is best qualified to state what new ones shall be inserted in the list. Once more, it should be remembered that purely commercial or business principles animate the druggist, who is only an educated tradesman, carrying on his business solely with the idea of large pecuniary recompense. That such reward is sought after by the majority of physicians is of course true, and were it not for the well-known lack of business forethought of professional men, they would see that an immense amount of pecuniary loss may ensue if they are listless and careless in regard to this most important subject. To any one who has given it a half hour's thought, it must be evident that all leaves, rhizomes, roots, or flowers of a plant must of necessity vary greatly in the quantity of the medicinal substances which they contain, and it has been proved again and again that fluid extracts vary as much as twenty per cent. in the amount of their active principles. Even such a commonly used drug as aconite has been found to vary from one to twenty per cent. in a dozen stores in New York and Philadelphia. The reason of this is evident when we remember that nothing is required of the druggist by the Pharmacopœia as to the strength of the crude drugs employed, and that the temptation must always be to buy the cheapest raw materials rather than the more highly priced assayed leaves or roots. The physician has too often to submit to unjust criticism because his patients fail to be benefited by the treatment they receive, and everyone sees cases get well after using a certain drug given by one doctor, although it has failed in the hands of another, simply because in one case the preparation used was poor and in the other good. Aside from the mere pecuniary loss entailed, the questions of life and death, humanity and personal confidence are at stake.

The query as to the manner in which this crying evil is to be put down is difficult of solution. For-

tunately we are possessed of the alkaloids of most of the remedies generally employed, and these should be resorted to in all cases where doubt can possibly exist. Be the means what they may, some clear, distinct plan of action should be reached when the wise-heads of the convention come together, which will do away with uncertain therapeutics and give the physician reliable tools with which to practise his calling.

## REVIEWS.

THE NATIONAL MEDICAL DICTIONARY; INCLUDING ENGLISH, FRENCH, GERMAN, ITALIAN, AND LATIN TECHNICAL TERMS USED IN MEDICINE AND THE COLLATERAL SCIENCES, AND A SERIES OF TABLES OF USEFUL DATA. By JOHN S. BILLINGS, M.D., LL.D., Edin. and Harv., D.C.L. Oxon., with the Collaboration of W. O. ATWATER, M.D.; FRANK BAKER, M.D.; S. M. BURNETT, M.D.; W. T. COUNCILMAN, M.D.; JAMES M. FLINT, M.D.; J. A. KIDDER, M.D.; WILLIAM LEE, M.D.; R. LORINI, M.D.; WASHINGTON MATTHEWS, M.D.; C. S. MINOT, M.D.; H. C. YARROW, M.D. Two volumes. Philadelphia: Lea Brothers & Co., 1890.

FAMILIARITY with the workings of the plan upon which these volumes have been constructed, attained after long-continued use of their contents, is the only trustworthy criterion upon which to base a thorough review. Inasmuch as sufficient time has not elapsed to permit the employment of such a test, two substitutes offer themselves—comparison with other works of similar character, and a necessarily limited search for words, phrases, and abbreviations as they are encountered in the medical literature of the day.

The labor of comparison quickly demonstrates that this work in accurate derivation, concise definition, and general adaptability, is the equal of all rivals and the superior of the majority. The search for terms current in medical literature reveals that the object of the Dictionary to supply those in use "in English, French, German, and Italian, including the Latin medical terminology of all these languages," has eventuated in a satisfactory consummation. Perhaps the most striking feature, in addition to the industry which has gathered practically every medical term in current use, is the rare skill in condensation which is displayed, so that each definition is concise, often necessarily brief, without, however, sacrificing clearness to this brevity. This commendable feature will appeal to every man who does not turn to a dictionary to find lengthy essays upon the words it contains, or go to an encyclopædia to hunt for mere definitions and synonyms. It would be comparatively easy to point out numerous characteristics which readily attract the busy student—the satisfactory method of cross references, the redefinition of synonyms of dissimilar form and orthography from the commonly used term, the association of the French, German, and Italian synonyms of important English and Latin names with the prime word, and the system of indicating pronunciation.

In addition to the "Dictionary-portion" of the volumes, a series of useful tables has been prefixed. These consist in tables of doses, poisons and their antidotes, the numbering of spectacle-lenses, tables showing the expectation of life, the relation of the girth of the chest to increasing height, the dimensions and weight of the organs of the human body, and comparative scales giving the equivalent of ordinary weights and measures in those of the metric system, as well as the comparison of thermometric scales. This section closes with the tables of foods and dietaries prepared by Professor W. O. Atwater.

The typography of the work is excellent. Each double-columned page, with its clear type, liberal spacing, and satisfactory indentations is grateful to the eye of him who reads, and a beautiful example of the publishers' wisdom and the printer's art.

Dr. Billings and his collaborators have built a Dictionary for which, without wishing to be unseemingly eulogistic, we have no words but praise. It fulfils all reasonable requirements and meets all sensible expectations. It cannot merely take rank with the standard works of the same character which have preceded it, because it outranks the majority. It at once assumes the position of a model to which all future efforts in a similar line must look for inspiration.

## SOCIETY PROCEEDINGS.

### M'DOWELL MEDICAL SOCIETY.

*Twenty-ninth Semi-annual Meeting, held at Henderson, Kentucky.*

#### MORNING SESSION.

The Society was called to order at 10 A.M., by the President, Dr. John E. Pendleton, of Hartford, Ky.

DR. A. MORGAN VANCE, of Louisville, read a paper on

#### ANTISEPTIC SURGERY,

in which he said that in the past ten years the great progress of surgery has been in proportion to the increased understanding and confidence in the power of antiseptic and aseptic methods of wound treatment. The day is not far distant when the surgeon will be ashamed to admit the formation of pus in a wound of his making, as he will know that it is from neglect that pus appears. The technique, he said, is to be acquired by reading the medical journals of the day, and making trials of the methods there described.

Dr. Vance then directed the attention of the members to the importance of certain details in the following words:

*Don't* fail, when possible, to have a general bath before doing a major operation.

*Don't* do any operation with suspicious hands; hot water, soap, nail-brush, and penknife should be carefully used by the principal and assistants before any operation. It is best to cut the nails very short, so there will be no place for germs to lodge.

*Don't*, just before or during an operation, put the fingers about your nose, eyes, or ears, or use a handkerchief, or shake hands with any one.

*Don't* pick up, or allow an assistant to touch, any

instrument, sponge, or suture that has fallen to the floor during the operation.

*Don't* bite off the end of a suture that it may the more easily be threaded.

*Don't* put a knife or other instrument in the mouth, or behind the ear, preparatory to its use.

*Don't* cough or sneeze over the operative field.

*Don't* fail, when possible, to have the patient bathed and clothing changed before an operation. When this is not possible, thoroughly cleanse the field, and never make or dress a wound where the surrounding parts have not been shaved.

*Don't* allow any visitor to handle the field of operation, after the patient is prepared, unless he is aseptic.

*Don't* allow visitors who are attending patients with gangrene, erysipelas, or puerperal fever to be present.

*Don't* fail to have the field of operation surrounded by warm sublimated towels.

DR. I. N. LOVE then made some remarks on the

#### MANAGEMENT OF FEVERS.

He said that all the cases of fever which come under our observation, after it is well established that they are continued fevers, no matter what the cause, require management rather than medication, though there are times when medication is an important part of the management. In fever cases the first step in treatment should be to clear out the sewers of the patient, keeping open the secretory and excretory organs, by giving full doses of calomel with compound jalap powder, followed by some saline purgative. Sometimes this in itself will overcome the fever, and then proper measures should be taken to prevent its recurrence.

The ice-water and milk given fever patients should have been boiled and kept hermetically sealed in an ice-chest. Cleansing the mouth and teeth are important factors, and no patient with typhoid fever should be allowed to have sordes on the teeth. An item of vital importance is tranquillity of both mind and body. Friends should not be permitted to see fever patients. The physician should insist upon the patient using a bed-pan, and saving muscular effort. With a view to producing this tranquillity, the administration of medicines which produce sleep are of great value. In controlling temperature the speaker highly recommended acetanilid, as he has used it in a large number of cases with very satisfactory results. Given in doses of two and a half grains, every two to four hours, to an adult, it reduces temperature at least one and a half degrees, and keeps it down. The speaker gives it in the form of a solution, with brandy or Tokay wine, which makes an ideal stimulant. He also alternates the sponge-bath with the administration of acetanilid.

Quinine, as an antipyretic, should be ruled out unless there is a malarial element, for the drug disturbs the nervous system and alimentary canal, and impairs digestion and nutrition.

Dr. Love, in closing, favored the pre-digestion of all foods for fever patients for various and obvious reasons, which he gave at considerable length. Bovinine is very satisfactory in such cases, as it is well received, well retained, and is unquestionably very nourishing.

DR. J. E. PENDLETON, of Hartford, Ky., read a paper on



## TREPHINING, WITH REPORTS OF CASES,

in which he said that trephining in itself is not a dangerous operation, but that it is usually done for the relief of some injury or pathological condition which either impairs the health or imperils the life of the patient. Operations done for the relief of epilepsy are more nearly fair examples from which to calculate the mortality rate than any other class of cases that have been recorded, but even in these, if the epileptic seizures be due to old traumatism of the skull, with spiculæ of bone or exostoses impinging upon the brain or its membranes, they should be excluded. It has not been the author's fortune to be called to use the trephine for tumors or epilepsy, and his experience with the instrument has been for the most part confined to recent traumatic injuries of the head. He then reported five cases upon which he had successfully operated.

Dr. Pendleton concluded by saying that though much had been learned and published within the last two decades upon the functions of the cerebral centres, we are not yet in possession of sufficient knowledge to shield us from the danger of making mistakes in locating cerebral lesions. The very complex anatomical arrangement of the nervous centres and their conducting tracts; the facts that two or more areas may be intimately connected with the same function, and that lesions of the same location in different individuals may not produce like definite results, conspire to hinder correct diagnosis. Tumors and abscesses deeply embedded in the brain substance and which would inevitably have destroyed life have been extirpated or evacuated and the patients restored to health. Perilous as may seem these daring ventures in brain surgery, the author said that those cases whose lives are made miserable by constantly recurring fits of epilepsy, and otherwise incurable, will gladly avail themselves of almost any operation to get rid of their malady. In depressed fractures, in subdural hæmorrhage, or in traumatic abscess, if the focal symptoms are of a positive character, there should be no hesitation about operating.

Judging from his own observation and the information he had gathered concerning the conditions of the skull and brain for which trephining may be done, he could only say that the propriety of operating depends chiefly upon our ability to make a correct diagnosis.

DR. E. H. LUCKETT, of Owensboro, Ky., read a brief paper on

## THE DUTIES OF MOTHERS IN NURSING THEIR CHILDREN.

He said that in investigating the operation of natural laws we cannot fail to observe the mutual relationship and reactions which they produce in their fulfilment, and that this relationship holds good whether they are acting rationally or aberrantly. In no field of their operation is this to be more observed than in the laws regulating biological processes or pathological divergencies. Each law as it applies itself to the development of functional activity in this or that organ is aided by its relationship. In but few organs is this law more beneficently displayed than in the milk glands and the uterus, where the one has for months been caring for a growing, and the other developing for the care of the infant in its independent existence. To set this order

ruthlessly at defiance is to invite serious disaster to the woman and greater perils to the child. There is no condition of humanity more to be deplored than that arising from the pathological conditions following childbirth, and among the many causes for these disturbances, failure to nurse stands out boldly and forebodingly. That every mother should nurse her child—except from want of milk or grave disease—will not be gainsaid; it is the demand made by the law of her condition and she cannot shrink from the task or transfer the responsibility without inviting injurious results to herself and taking large chances for physical and mental defects to her child, entailing upon it a puny existence and too frequently an early death. With women who were unable to nurse their children pregnancy might occur every ten to fifteen months, subjecting her to all the mental anxieties, all the nerve perturbations, both reflex and direct, and all the functional derangements incident to the condition almost continually during her sexual life.

Another accident arising frequently in the non-nursing woman is abortion, which is no doubt to a great extent the result of the frequent pregnancies to which such women are subjected. These abortions are fruitful causes of local pelvic troubles, both acute and chronic, and add largely to the list of penalties which women pay for neglect of duty, in discarding the motherly care of their offering.

DR. BRANSFORD LEWIS, of St. Louis, Mo., then read a paper on the

## TREATMENT OF GONORRHOEA WITH OINTMENTS,

in which he deprecated the use, in the early stages of gonorrhœa, of astringents, caustics, or other means, antiseptic or otherwise, which would tend in any way to increase the irritation already present, giving as his reason that, aside from the irritation which they produced, they were inefficacious in reaching or killing the gonococci, the morbid agents, because of the location of the latter in the tissues. Admitting the inability to cut short a gonorrhœa in a few days or a week, he had devised a plan of treatment having for its object the conduction of the disease through its several stages as quickly, as comfortably, and as safely as possible, and nothing appeared to him to be more likely to attain these ends than the introduction of a bland ointment, medicated as desired. It is soothing to the inflamed membrane; it keeps the opposing surfaces from rubbing against one another, and in this way obviates all auto-irritation. It affords a continuous application of any medicament, with but little trouble to the physician or annoyance to the patient.

Dr. Lewis then exhibited the instrument or applicator which he uses, and described it as a hard-rubber ointment box, fitted at one end with a screw-piston for pressing the ointment out of the other end into a soft-rubber catheter attached. The catheter, having three holes at its end, is a No. 2 French, sufficiently small, smooth, and flexible to glide for a half inch or so into the most sensitive urethra, generally before the patient knows that it is in. The ointment is then squeezed out, pressure being maintained around the glans, so that it is compelled to pass backward over the inflamed area. The catheter is then withdrawn and a muslin hood, lined with clean,

non-absorbent cotton, is placed over the penis, and retains the application until the next urination.

Lately he had been using albolene, an ointment base which is such an inert substance that it neither changes nor becomes rancid with keeping or in combination with medicines. It is odorless and almost tasteless. He prefers it to lanolin because of the qualities mentioned, and is now using it exclusively and with perfect satisfaction.

DR. WILLIAM CHEATHAM, of Louisville, Kentucky, then read a paper entitled

#### PHLYCTENULAR OR SCROFULOUS OPHTHALMIA,

in which he said that in this disease the hygienic management and the constitutional treatment are of extreme importance, as the most frequent cause of the affection is bad hygiene. As to feeding, all sweets, tea and coffee should be interdicted. Fresh meat should, if possible, be given twice a day, but not at night, and the patient should be kept out of doors as much as possible. In the local treatment of phlyctenular conjunctivitis, frequent washing with carbolyzed water, hot or cold, as the patient prefers, is of great importance. A solution of two grains of sulphate of atropine in an ounce of distilled water should be dropped into the eye three or four times a day if the inflammation is severe, or if there is photophobia. If dry calomel can be dusted into the eye about noon each day, with a camel's-hair brush, it should be done, or the calomel may be mixed with pulverized white sugar, half and half.

#### EVENING SESSION.

DR. P. THOMPSON, of Henderson, made some remarks on the

#### HYGIENIC MANAGEMENT OF THE NEWBORN.

DR. G. FRANK LYDSTON, of Chicago, followed with a paper on the

#### EVOLUTION OF THE LOCAL VENEREAL DISEASES,

in which he said he was convinced that chancroid and gonorrhœa are diseases which may arise *de novo*, and which are, in the true sense of the term, not specific. It is only by an acceptance of this theory that it is possible to understand something of the origin of those diseases. It may not be possible to demonstrate the origin of all infectious diseases, but it is incomprehensible that a "specific" poison has always existed. The germ theory apparently throws some light upon the origin of infectious diseases. Diseases are incident to the life of every animal, and as we study the evolution of the animal, so should we study the evolution of its diseases.

He believed that the local venereal diseases are the result of the propagation and differentiation of germs primarily innocuous, and that the innocent germs of the atmosphere may multiply in a favorable environment, and the result of such multiplication finally become through successive cultures virulent. Thus the descendants of innocuous germs may have properties which are innocuous or virulent depending upon the environment in which they are developed.

The effects of the germ, even after it enters the tissues of the human being, vary according to (1) its virulency and vitality; (2) the inherent vitality of the individual

affected; (3) idiosyncrasy; (4) activity of elimination; (5) the condition of the tissues; (6) the number of germs and length of time of exposure.

The experiments of Pasteur on chicken cholera show conclusively what may be done in the way of modifying germs by proper culture, and is it unreasonable to suppose that such cultivation may occur in nature's laboratory? As a consequence of the great variation in the circumstances controlling the development of germs in the female vagina, the essayist believes that there may result from different inoculations of essentially the same products of evolution different degrees of infection. Thus the disease acquired by exposure to such germs may be a simple balanitis, balano-posthitis or venereal vegetations, simple urethritis, virulent urethritis, simple venereal ulcer indistinguishable from advanced herpes, or, lastly, the true chancroid.

## CORRESPONDENCE.

### PARIS.

*Influenza in Europe; Symptoms; Nature; Contagiousness and Treatment.*

To the Editor of THE MEDICAL NEWS,

SIR: Influenza, the interesting disease of the moment, does not seem to be on the decrease in Europe. The reports from all the European capitals indicate, on the contrary, that the number of cases is on the increase, and, what is still more important, that the disease is taking a more severe form. The mortality has apparently doubled and tripled in every city where the disease has shown itself. The real nature of the disease does not seem to have been as yet determined; the greatest medical authorities of Europe are differing on this subject, some believing the affection to be influenza, others considering it dengue fever, while still others admit that the epidemic possesses characters common to both influenza and dengue.

As has been many times stated, the disease was first observed in Russia, where it appeared about the beginning of October. It first occurred in isolated cases, but soon, however, took the form of a true epidemic, which no sanitary measures could prevent. In Russia, the principal symptoms which were observed were as follows:

Most of the patients were taken suddenly, after one or several chills, with a temperature rising to 102° or 104° F. A few moments before this fever, however, the patient usually complained of severe pain in the frontal region. In others, the disease began after several chills, accompanied by a tired feeling, with severe headache, this lasting for twenty-four hours, at the end of which, the temperature reached its highest point.

Again, others felt ill for three or four days, or even a week; they complained of general muscular and intellectual fatigue, great irritability of the nervous system, headache, loss of appetite, sleepiness, etc. Others complained of sore throat of short duration. In young men, the disease usually started abruptly, while in elderly persons there always existed premonitory symptoms. For the first two or three days the patient complained of frontal headache, pain in the muscles of the posterior cervical region, in the sacro-lumbar region, in the legs,

chest, cardiac region, abdominal parietes, or in the articulations. In some, nausea and repeated vomiting have been observed, also delirium. All patients presented more or less depression. Cough presented a convulsive character, dry, or accompanied by mucous expectorations. Most of these cases had the appearance of typhoid fever patients.

In three cases, at one of the St. Petersburg temporary hospitals, a diffused erythema was observed, resembling very much the rash of scarlatina, which, however, disappeared by the second day. In some cases, conjunctivitis, photophobia, and pain in the ocular muscles were noticed. The pharynx was more or less hyperæmic, while the tonsils and sub-maxillary glands were somewhat increased in size. The pulse was small and frequent. In regard to the lungs, bronchitis was observed, but rarely pneumonia. The liver and spleen were found increased in size. A slight amount of albumin in the urine was often discovered. On the third or fourth day the temperature usually fell, and there appeared a more or less profuse perspiration; in about half the cases the temperature went up again on the fourth, fifth, or sixth day, but this febrile state only lasted a day or two, when convalescence would begin.

In Belgium the disease began as elsewhere, by striking collections of people, such as are found in the large stores; in most of these more than two-thirds of the persons were attacked.

M. Renvers, of Berlin, as a result of his recent observations, divides influenza into three clinical varieties: The first is the violent form of the disease, with severe headache, pain throughout the body, and great elevation of temperature. In a few hours the headache becomes extremely painful, the patient complains of nausea, is agitated, face is flushed, and the temperature rises to  $104^{\circ}$  or  $105^{\circ}$ . Ten or twelve hours later appear the respiratory symptoms, then profuse sweats, and the disease finally disappears. During the short convalescence there is great fatigue, with pain in the limbs and back.

The second form presents an ascending temperature for one or two days; irregular pains in the limbs, violent cough, dry mouth, etc.; the cough is convulsive, and liable to bring on vomiting. Temperature remains at its maximum for two days, and then gradually descends, but it is from four to five days before all the catarrhal symptoms disappear.

In a third form symptoms appear simultaneously in the organs of respiration and those of digestion. In this form we find a predomination of the nervous symptoms, with loss of appetite. The temperature rises rapidly and the fever may last two or three days. At the beginning these cases resemble typhoid fever.

The complications observed are broncho-pneumonia and fibrinous pneumonia. This pneumonia is peculiar in not presenting rusty sputa nor great cough, but on percussion there is a certain amount of dullness. In some cases erythema of the skin has been observed.

M. Fürbringer, of Berlin, has observed 47 cases of influenza—40 men and 7 women, aged between 16 and 25 years—which is a contradiction of the ordinarily accepted theory that the disease is much more apt to seize elderly people. He has observed fibrinous pneumonia in only two cases, and admits the existence of an

abortive broncho-pneumonia only when he finds traces of blood in the sputa. As regards treatment, he thinks the antipyretics useless, as the patients recovered without any active treatment. He does not consider the disease contagious, but rather thinks it a miasmatic disease, due to an organism in suspension in the air.

In Paris, as in the other large cities, the epidemic was first noticed in the largest dry goods store, which employs from 2500 to 3000 employés; the very first day over 300 were taken sick, and in three or four days two-thirds of them were ill. The sanitary physicians who were ordered to examine the character of the disease reported it as being influenza, or grippé. Since then the epidemic has spread over Paris, and markedly increased the mortality for the month of December. The disease in itself is not dangerous, but the mortality is due to the complications to which it gives rise when the patients neglect themselves. As an example of the increase of mortality, during the month of December, 1888, there were 3784 deaths in Paris; during the month of December, 1889, the number of deaths increased to 5969, which gives a difference of 2185 in favor of this year. Examining the statistics in detail, we find that in one week only 22 deaths are reported under the title influenza, while under the head pneumonia, which, in the corresponding week of 1888 gave a mortality of 67 deaths, gives this week 346 deaths; acute bronchitis, which gave 42 deaths, has this year 131; chronic bronchitis, 127 deaths, instead of 47; broncho-pneumonia, 138, instead of 27. The diseases of the respiratory organs have caused a total of 742 deaths, instead of 200, which is the ordinary number at this period of the year. Pulmonary congestion, phthisis, cardiac diseases, hemiplegia, old age—all present a high mortality, certainly due to the existing epidemic.

The question was brought before the Académie de Médecine, where Professor Sée stated that he thought from the result of his observations that the disease was of an infectious nature, having observed in most of the cases that there was an increase in size and a certain tumefaction of the spleen, as is found and observed in typhoid fever and malaria; and he even thinks that the pneumonias which are found as a complication of the influenza are of an infectious nature, as they do not present the ordinary signs of pneumonia—no rusty sputa are observed, very little cough, etc.

Dr. Dujardin Beaumetz states that the present is quite different from preceding epidemics; there are a few new symptoms which are not described as belonging to the disease. The disease begins abruptly, as does dengue fever; persons are taken in the midst of their occupations. In this epidemic two periods are also observed, as in the dengue fever. The first, called the nervous period, presents no catarrhal symptoms, but nausea, vomiting, agitation, even delirium, are observed. The second period resembles very much influenza, and is characterized by a catarrhal fever with mucous-membrane manifestations. Finally, Dr. Dujardin Beaumetz finds another resemblance to dengue fever, namely, the eruption and the physical and moral depression which are present.

The surgeons of the navy, who have had ample opportunity of studying dengue fever in regions where this disease prevails endemically, also find resemblances



between it and the present epidemic. Even those who assert that the present disease is influenza, admit that it is an irregular form.

Professor Grasset, of Montpellier, is ready to admit that the disease is influenza, but a special form of influenza, which brings it very close to dengue fever.

Dr. Corre, of the French navy, although believing that the disease is influenza, yet says that it would not be illogical to admit that it is a hybrid, as the disease has originated in a country where the influenza and dengue prevailed at the same time, and that both these diseases have come to us mixed in different proportions, according to the climatic conditions.

Another surgeon of the navy, Dr. Dangny des Déserts, who has observed the disease on board a naval schoolship, concludes that the disease is not influenza, but an attenuated form of dengue fever. He says that the present disease begins much more like dengue than like influenza. In regard to the eruption, this is always present in severe cases of dengue, but it may be absent in light forms. In 1873 he observed in Cochin China a great many cases of dengue fever, and in a large number of light cases the eruption was absent. During the present epidemic he has seen scarlet eruptions followed by desquamation in several cases. As a conclusion, Dr. des Déserts says that the actual disease not only presents the symptoms of dengue as observed in the colonies in mild cases, but differs from influenza by the fact that coryza and inflammation of the bronchial passages are very often absent.

In Berlin and in St. Petersburg several physicians still hesitate between the nature of the disease. What everyone seems to admit, however, is that the influenza observed at present does not occur with all the classical symptoms usually encountered; it is an abnormal influenza—perhaps even an unknown or not yet described disease.

As regards prognosis, Dr. Dujardin Beaumetz thinks it favorable when a healthy organism is involved, but, on the contrary, very grave when it strikes a broken-down constitution, and in certain cases it will accelerate the fatal termination of an already existing disease.

Certain physicians claim that the rash which has been observed in several cases of influenza was due to the internal administration of antipyrin; Professor Sée and several other practitioners have found the rash only on persons who took quinine.

In certain cases, the complications extend toward the middle ear, causing deafness and otitis; in one case, the inflammation was so great as to produce an inflammation of the mastoid cells, which required trephining of the mastoid process.

At Copenhagen, an unusual complication has been observed; the nasal inflammation which usually announces the disease, extends to the larynx and there becomes so intense, that œdema of the glottis has resulted and several tracheotomies had to be performed.

Great difference of opinion has been expressed as to the contagious character of the disease; the medical societies of Berlin and Paris seem to consider it non-contagious, while certain well-observed facts render its contagious character almost out of question. Professor Grasset, of Montpellier, has obtained the following observation from Dr. Bordone. A gentleman left Paris to

go to Frontignan, where he arrived on December 15th, and was immediately taking sick. On the 17th he gave a dinner to which ten persons were invited. On the 19th five out of these ten persons were taken. On the 18th he resumed his work. His second clerk, who resided several miles from Frontignan, was taken on the 21st and remained at home four days. On the fifth day of his disease, his mother, who nursed him, was taken sick. Up to the 15th not one case had been observed, and on December 24th there were 16 cases in Frontignan, and 6 in the neighboring village mentioned above. This certainly proves that the disease is communicable from one person to another.

The best example of contagion, however, is the one reported by Dr. Dangny des Déserts, who is the head surgeon of the naval school ship "La Bretagne," which has a crew of eight hundred and fifty men. From December 14th to January 1st, he has treated two hundred and fourteen patients. Two other naval school ships which are anchored very near, have had no case of the disease; hence the epidemic on board "La Bretagne," cannot be of a climatic nature. The way in which the contagion took place is explained as follows: On December 11th, a naval officer residing in the town, received two large boxes from a grocer in Paris. The boxes contained small cans which were enveloped in wood chips or shavings. Dr. Déserts took them out of the box; three days later he was seized with influenza; the following day, his wife and three servants presented symptoms of the disease. On December 14th this officer, still suffering from the disease, came on board "La Bretagne," where he remained twenty-four hours. On the 17th the epidemic was established, from twenty to forty-five men a day, presenting themselves at the infirmary. All the officers who were permitted to leave the ship, to be treated at their home, communicated the disease to their families.

In regard to the treatment: The usual method adopted seems to be to give the patient a purgative mineral water at the beginning of the attack, while at the same time antipyrin, fifteen grains, is given if the headache is severe, and if the fever is high.

Another treatment has also lately been recommended; this is based on the hypothesis that influenza is an infectious disease; and as the disease, in many cases, has taken an almost strictly abdominal form, intestinal antiseptics such as have been recommended by Professor Bouchard in typhoid fever, are being used.

As soon the patient has the first attack of fever, he must be given every hour four grains of salol, until thirty grains have been administered or even forty-five grains in an adult; three times daily ten grains of naphthalin are given.

In eight cases out of ten, the fever will disappear after the first day of this treatment, which should be continued for four or five days.

Persons or patients who were already taking either salol or naphthol for some other purpose, have very rarely contracted influenza.

The treatment which is recommended by Dr. Dujardin Beaumetz is as follows:

In case, where there exists a great deal of pain, antipyrin and exalgine are the remedies which give the best results. Thirty to forty-five grains of antipyrin are adminis-

tered in a hot punch or in tea and rum. The following formula he recommends for the use of exalgine:

R.—Exalgine . . . . .	37 ½ grains.
Tinct. of peppermint . . . . .	5℥ss.
Syrup of orange flowers . . . . .	3j.
Water . . . . .	3iv.—M.

A teaspoonful every morning and evening. If there is periodical fever, quinine is to be used, four grains of the hydrochlorate morning and evening.

In the catarrhal form, he recommends tincture of aconite, taken three times a day as follows:

In a cup of milk put two tablespoonfuls of sirup of tolu; one teaspoonful of cherry laurel water; ten drops of the French tincture of aconite root. This mixture to be given three times a day. As a continuous drink for the patient tea seems to be best supported.

Of course, if the febrile, painful or catarrhal forms of the disease, are associated, the above mentioned drugs should be combined accordingly.

#### THE MEDICAL SOCIETY OF SOUTH CAROLINA.

To the Editor of THE MEDICAL NEWS,

SIR: On the 9th day of December, 1889, the Medical Society of South Carolina celebrated its one hundredth birthday. This Society is the third oldest medical society in the United States, it being antedated by that of Massachusetts and the College of Physicians of Philadelphia. Among its founders was David Ramsay, the noted physician and historian, who was a native of Pennsylvania, and one of the earliest, if not the first graduate from the University of Pennsylvania. This Society has always held an honored position in South Carolina, and many of her sons have been known not only throughout this country but in Europe. For many years her members constituted the Board of Health, and were always consulted by the city authorities upon all sanitary matters. In 1724 the Society obtained from the General Assembly a charter for a medical college—the original medical college of this State—the Medical College of South Carolina. The professors were chosen from the members of the Society, and students applying for their degrees were examined before and by members, and the degrees were conferred by the Society. Finally, a controversy arose between the professors and the Society, which ended in the former resigning their chairs, obtaining a charter for a new college, called the Medical College of the State of South Carolina. This prospered, and though the Society filled the vacant chairs of the original college with bright minds from at home and abroad, its day was over, and it finally succumbed, leaving the new College in a flourishing condition. From its many eminent men have been graduated, and it is still pursuing its mission.

The Society celebrated its centennial by an oration which was delivered by Dr. Cornelius Kollock, of Cheraw, S. C., and afterward adjourned to partake of a handsome banquet at the Charleston Hotel.

The Roper Hospital, supported by the Roper Fund, for which the members of the Society are the trustees, is being repaired after the damages caused by the earthquake, and will, in all probability, be opened at no very distant date.

The officers of the Society for the ensuing year are as

follows: President, T. Grange Simons, M.D.; Vice-President, R. L. Brodie, M.D.; Treasurer, J. L. Dawson, Jr., M.D.; Secretary, Charles M. Rees, M.D.; Librarian, Walter P. Porcher, M.D.

#### ST. PAUL AND MINNEAPOLIS.

To the Editor of THE MEDICAL NEWS,

SIR: There have not been many events of interest in a medical way in St. Paul or Minneapolis lately.

Dr. Vincent J. Hawkins, of St. Paul, has performed a Cæsarean section upon a dwarf, and both mother and child are alive and well.

The patient was seventeen years of age, 3 feet 5 inches tall, measured 30 inches around the hips and weighed 55 pounds. The conjugate diameters were 1 ¼ inches, the lateral diameter 3 ¼ inches.

The operation was begun two hours after the onset of labor pains and was performed in the usual manner, with antiseptic precautions. The patient suffered from collapse during the first twenty-four hours, and the highest temperature was reached on the fifth day: from this time she made an uninterrupted recovery.

The Medical Department of the University of Minnesota has started out with a class of eighty-seven students, and is flourishing.

Dr. Van der Horck, of Minneapolis, has under his care two cases of leprosy of the tuberculous variety; they are both Swedes; the older one is totally blind and suffering from tuberculosis of the lung.

It may interest the graduates of Jefferson Medical College to know that our State Board of Examiners has refused graduates of that school admission to our State examinations for license to practise medicine in Minnesota, on account of the shortness of the course of study. Our State law requires that to be eligible for examination, the candidate must be a graduate of a medical school having a graded course of at least three sessions of six months each.

#### A CORRECTION.

To the Editor of THE MEDICAL NEWS,

SIR: In looking over an article "Three Cases of Appendicitis; Operation; Recovery," by J. M. Baldy, M.D., of Philadelphia, which appeared in THE MEDICAL NEWS for November 23, 1889, I notice that on page 580 he makes the following remark: "In this case (mentioning my name) the appendix itself, after being freed from its adhesions, was allowed to remain, it being considered healthy enough to do no harm." Dr. Baldy must certainly have forgotten the operation, for the appendix was ligated and cut off, and moreover I have the identical appendix in a bottle of alcohol in my office.

Yours truly,

EUGENE P. BERNARDY.

#### NEWS ITEMS.

*Regulations of the Tenth International Medical Congress.*—The following are the more important regulations of the Tenth International Congress:

I. The Tenth International Medical Congress will be opened in Berlin on Monday, August 4, 1890, and will be closed on Saturday, August 9th.

II. The Congress shall consist of legally-qualified medical men who have inscribed themselves as members, and have paid for their card of membership. Other men of science who interest themselves in the work of the Congress may be admitted as extraordinary members.

Those who take part in the Congress shall pay a subscription of twenty marks (five dollars) on being enrolled as members. For this sum they shall receive a copy of the *Transactions*, as soon as they appear. The enrolment shall take place at the beginning of the Congress. Gentlemen may, however, be enrolled as members by sending the amount of the subscription to the Treasurer,<sup>1</sup> with their name, professional status, and residence appended.

III. The object of the Congress is an exclusively scientific one.

IV. The work of the Congress will be discharged by eighteen different Sections. The members shall declare, upon enrolment, to which section or sections they intend more particularly to attach themselves.

V. On account of the different languages employed, a suitable number of secretaries shall be chosen from among the foreign members. The duties of the foreign secretaries shall be confined to the sittings of the Congress.

After the termination of the Congress, the editing of the *Transactions* shall be carried out by a committee specially appointed for this purpose.

VI. The Congress will assemble daily, either for a general meeting or for the work of the different sections. The general meetings will be held between 11 and 2 o'clock. Three such meetings will take place.

VII. The general meetings shall be devoted to (a) transactions connected with the work and general management of the Congress; (b) speeches and communications of general interest.

VIII. Addresses in the general sittings, as well as in any extraordinary meetings which may be determined upon, can only be given by those who have been specially requested by the Committee of Organization.

Proposals relative to the future management of the Congress must be announced to the Committee of Organization before July 1, 1890. The Committee shall decide whether these proposals are suitable to be introduced for discussion.

IX. In the sittings of the sections, questions and problems will be discussed, which have been agreed upon by the special committees of organization. The communications of those appointed by the committee to report on a subject shall form the basis of discussion. As far as time allows, other communications or proposals proceeding from members, and sanctioned by the Committee of Organization, may also be introduced for discussion. The bureau of each section decides as to the acceptance of such offered communications, and as to the order in which they shall come before the meeting, always provided that this point has not been already determined in the sitting itself by a decree of the section.

Scientific questions shall not be put to the vote.

X. Introductory addresses in the sections must, as a rule, not exceed twenty minutes in length. In the discus-

sions no more than ten minutes are allowed to each speaker.

XI. All addresses and papers in the general and sectional meetings must be handed over to the secretaries, in writing, before the end of the sitting. The Editorial Committee shall decide whether, and to what extent, these contributions shall be included in the printed *Transactions* of the Congress. The members who have taken part in the discussions will be requested to hand over to the secretaries, before the end of the day, in writing, the substance of their remarks.

XII. The official languages of all the sittings shall be German, English, and French.

XIII. The acting president shall conduct the business of each meeting according to parliamentary rules.

XIV. Medical students, and other persons, ladies and gentlemen, who are not physicians, but who take a special interest in the work of a particular sitting, may be invited by the president or be allowed to attend the sitting by special permission.

XV. Communications or inquiries regarding the business of separate sections, must be addressed to the managing members thereof. All other communications and inquiries must be directed to the General Secretary, Dr. Lassar, Berlin N.W., 19 Karlstrasse.

**Hydrophobia from the Bite of a Cat.**—Principal Clark, of the Albion Academy, at Milton, Wisconsin, is reported to have died from hydrophobia, resulting from the bite of a cat ten months previously. The immediate effects of the bite appeared to be trivial, but the hydrophobic symptoms, when they declared themselves recently, were unmistakable and death most painful.

#### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JANUARY 28 TO FEBRUARY 3, 1890.

By direction of the Secretary of War, the extension of leave of absence granted C. N. BERKELEY MACAULEY, *Captain and Assistant Surgeon*, in S. O. 294, A. G. O., December 18, 1889, is further extended one month.—Par. 1, S. O. 22, A. G. O., January 27, 1890.

MIDDLETON, JOHNSON V. D. *Major and Surgeon*.—Is granted leave of absence for fifteen days.—Par. 9, S. O. 21, *Headquarters of the Army*, A. G. O., January 25, 1890.

#### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF THE MEDICAL CORPS OF THE U. S. NAVY, FOR THE WEEK ENDING FEBRUARY 1, 1890.

RUSH, C. W., *Passed Assistant Surgeon*.—Detached from the Naval Academy, and placed on waiting orders.

DECKER, C. J., *Assistant Surgeon*.—Ordered to the Naval Academy, February 1st.

GREEN, E. H., *Passed Assistant Surgeon*.—Detached from the "Alert," and placed on waiting orders.

BEARDSLEY, G. S., *Medical Inspector*.—Granted extension of leave to April 30th, with permission to remain abroad.

**THE MEDICAL NEWS** will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.

Local papers containing reports or news items should be marked. Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the **NEWS** should be addressed to No. 1004 Walnut Street, Philadelphia.

<sup>1</sup> Treasurer's address: Dr. M. Bartels, Berlin S.W., Leipsigerstrasse 75. Please enclose a visiting-card.